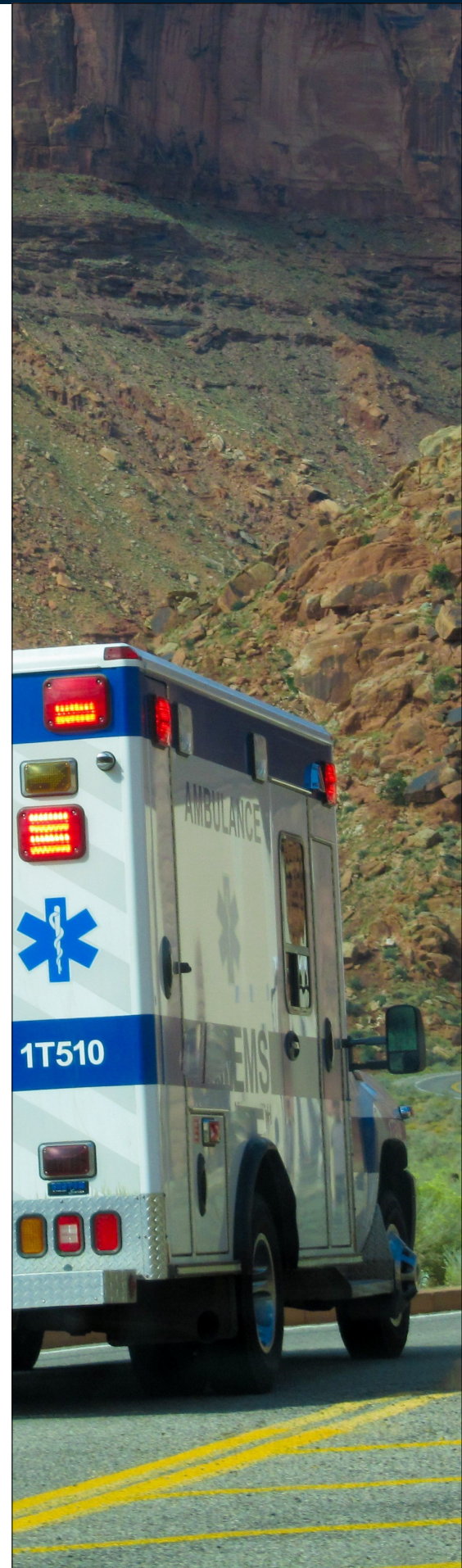


Volunteer Providers of Emergency Medical Services

Office of Performance Evaluations
Idaho Legislature





Senator Mark Harris (R) and Representative Ilana Rubel (D) cochair the committee.

Office of Performance Evaluations

Established in 1994, the legislative Office of Performance Evaluations (OPE) operates under the authority of Idaho Code §§ 67-457–464. Its mission is to promote confidence and accountability in state government through independent assessment of state programs and policies. The OPE work is guided by professional standards of evaluation and auditing.

Joint Legislative Oversight Committee 2021–2022

The eight-member, equally bipartisan Joint Legislative Oversight Committee (JLOC) selects evaluation topics; OPE staff conduct the evaluations. Reports are released in a public meeting of the committee. The findings, conclusions, and recommendations in OPE reports are not intended to reflect the views of the Oversight Committee or its individual members.

Senators



Mark Harris



Dave Lent



Michelle Stennett



Dave Nelson

Representatives



Ilana Rubel



Caroline Nilsson Troy



Paul Amador



Steve Berch

From the director

November 16, 2021

Members
Joint Legislative Oversight Committee
Idaho Legislature

We found support for many of the concerns raised by legislators in their request for our office to examine emergency medical services (EMS) staffing issues.

Funding challenges lead many EMS agencies, especially rural ones, to rely on volunteers. Insufficient staffing means patients in these areas face longer wait times and receive a lower standard of care. The COVID-19 pandemic has worsened these concerns, according to several EMS agency officials. Agencies must submit patient care reports to the Department of Health and Welfare's Bureau of EMS and Preparedness, but several factors lead this data to be inaccurate and incomplete. As a result, the state has little information about the scale and location of staffing issues.

We recommend that the bureau address data limitations by providing more support to agencies for required patient care reports. The bureau should use this data to proactively reach out to agencies that struggle with staffing issues to help ensure temporary coverage by another agency, create a service improvement plan, and provide other technical assistance based on evidence.

The bureau and agencies reported that funding is a significant limiting factor. The Legislature could support agency recruitment and retention efforts by providing financial compensation, training, and benefits such as health insurance and retirement savings for volunteers.

I would like to thank all the EMS volunteers and paid providers who participated in this evaluation. I would also like to thank officials with local EMS agencies, the bureau, the EMS Physicians Commission, the Time Sensitive Emergency System Council, and the EMS Advisory Committee.



Sincerely,



Rakesh Mohan, Director
Office of Performance Evaluations



954 W. Jefferson Street
Suite 202
Boise, Idaho 83702
Ph. 208.332.1470
legislature.idaho.gov/ope/

**Formal
responses from
the Governor and
the Department
of Health and
Welfare are in
the back of the
report.**



Sasha O'Connell and Mackenzie Moss conducted this evaluation with assistance from Amanda Bartlett and Madeline Gere.

Technical assistance and quality control were provided by Dr. Curtis Sandy of Portneuf Medical Center, Bob Thomas of Robert C. Thomas and Associates, and Elizabeth Grim of Elizabeth Grim Consulting, LLC.

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Executive summary



Why we were asked to do this study

Emergency medical services (EMS) provide out-of-hospital acute care and transport. In general, state and local organizations manage the development, funding, and maintenance of EMS. Like other states, Idaho has relied on volunteers to help staff EMS, especially in rural areas.

In our 2010 evaluation, *Governance of EMS Agencies in Idaho*, we found that Idaho's system was fragmented and built on a statutory framework that had not kept pace with the evolution of EMS. The Joint Legislative Oversight Committee approved a request during the 2021 legislative session asking us to evaluate any improvements to EMS administration and examine policies to address challenges in recruitment and retention of EMS volunteers.

What we found and next steps

Idaho does not designate EMS as an essential government service and therefore does not guarantee access for all Idahoans. The Department of Health and Welfare's Bureau of EMS and Preparedness reported that it has limited authority and capacity to expand its support of local EMS agencies.

Agencies face funding challenges, leading many to rely on volunteers to provide EMS. Inadequate staffing affects patient care because of less advanced training and delayed response times, especially in rural areas. The state knows little about the extent to which patient care is affected because the bureau does not have accurate and complete performance data.

We recommend that the bureau address data limitations that restrict the ability to increase and target support for staffing issues in an evidence-based manner. The Legislature could support agency recruitment and retention efforts by providing financial compensation, benefits, and training.

Idaho still does not have a statewide structure for collaborative governance of EMS.

The state has made little progress on our 2010 recommendations.

In our 2010 evaluation, we found that statute does not designate a governing body with the authority to limit service duplication, require statewide coverage, or mandate cooperation among agencies. We recommended that the Legislature increase the bureau's role in governing EMS.

We found that the bureau still operates primarily as a regulatory body with limited authority and capacity to expand its support of EMS agencies. The bureau can revoke licenses of agencies that do not meet existing requirements, but reported concerns that doing so would leave areas without EMS. Although agency officials we interviewed also noted this concern, some reported that the bureau's limited authority and hesitancy to enforce existing licensure requirements, in particular the response requirement, act as barriers to improving EMS standards.

The bureau does not formally track mutual aid or other cooperative agreements between agencies. Although the bureau reported that it encourages agencies to develop their own systems, it does not have a mechanism to facilitate ongoing coordination between agencies in each region. Of agency directors who responded to our survey, only 36 percent reported being part of a formal partnership to increase service coverage, minimize resource duplication, or provide consistent standards of care. Idaho still does not have a statewide structure for collaborative governance of EMS.

Most agencies reported inadequate funding, with rural agencies facing the most challenges.

EMS expenses include the direct cost of each emergency response and ongoing overhead to keep the operation ready to respond 24 hours a day, 7 days a week. Our 2010 report found that the state did not follow nationally recommended practices for funding EMS. Idaho still does not have a formula to determine the cost of readiness and ensure EMS agencies are funded accordingly. Agencies rely on different funding models and a patchwork of funding sources.

More than half of agency directors responding to our survey reported that they did not have sufficient funding to meet the emergency medical care needs of their community. Varied staff capacity and resources for billing systems limit knowledge about

the scale of financial shortfalls reported by agencies. Agencies reported that in many cases they cannot cover their costs through billing because reimbursement rates are low, some on-site treatment does not qualify for reimbursement, and some treated patients do not have health insurance or the financial resources to pay.

EMS agencies must pay for unreimbursed care to stay financially solvent and not affect services for their community. Although some agencies in Idaho reported sufficient revenue for capital improvement, vehicles, and equipment, many agencies reported increasingly limited options to raise revenue for staffing, especially in rural areas.

Some property tax funding can be used by agencies for EMS staffing. Agencies may receive property tax revenue through their county, city, hospital district, fire protection district, or ambulance service district. Property taxes have statutory restrictions intended to suppress tax growth. More than half of ambulance service districts and fire protection districts were restricted in their ability to cover any remaining costs through property taxes. Nearly 86 percent of ambulance service districts and 90 percent of fire protection districts were at 95 percent of their maximum taxing capacity.

Districts could ask voters to raise property taxes past the budget restrictions. However, many agencies reported that their community cannot afford a property tax increase. Agencies could increase service fees and more aggressively go after outstanding bills to recover costs, but officials reported being fearful that people would no longer call 911 when they need help. Instead, when agencies struggle financially, they often end up asking more from existing staff and trying to find people who are willing to provide emergency medical care for their communities without compensation.

Agencies reported insufficient staffing to meet the needs of their communities.

Idaho has nearly 2,000 EMS volunteers, making up over 40 percent of EMS providers statewide. In rural Idaho, 69 percent of EMS providers are volunteers. The number of EMS providers has not kept up with population growth. Stakeholders reported that recruiting and retaining sufficient staff is one of the biggest challenges for EMS in Idaho. Just 18 percent of agency directors who responded to our survey reported being able to maintain sufficient staff to meet the needs of their community.

More than half of agency directors reported having insufficient funding to meet the needs of their community.

69% of EMS providers in rural Idaho are volunteers.

Staffing issues contribute to disparities in patient care. Response times and standards of care vary widely across the state.

Agency officials we interviewed consistently reported that not every Idahoan gets the level of care they need during an emergency. They cited insufficient staffing as the primary reason. Paid providers are 3.6 times more likely than volunteers to be licensed to provide intermediate or advanced life support.

When agencies cannot recruit and retain staff, response times increase because agencies must service larger areas with fewer active stations and neighboring agencies must step in to help. Idaho Code requires agencies to respond to emergencies 24 hours a day in the agency's declared service area. About 65 percent of agency directors responding to our survey reported that lack of staff availability caused them to be delayed by more than 15 minutes or unable to respond to a call in the past year. About 33 percent of agency directors reported that lack of staff availability affected response times at least monthly.

We recommend that the bureau improve monitoring and technical assistance for agencies to meet the response requirement.

We found that ongoing data limitations restrict the state's ability to increase and target support for staffing issues in an evidence-based manner. The bureau is tasked with overseeing licensure of agencies, but it is currently unable to tell whether agencies are meeting their requirement to respond to emergencies 24 hours a day in their service area.

Agencies must provide the bureau with patient care reports, which include information on response time, patient conditions, and services administered. The bureau did not have accurate and complete patient care report data on 74 percent of emergency response calls by primary transport agencies in 2020.

Reliable patient care reports would allow the bureau to proactively reach out to struggling agencies to help ensure temporary coverage by another agency, create a service improvement plan, and provide other technical assistance. Limited data has restricted the bureau's ability to serve as a knowledge base and information clearing house.

That means the bureau is not as strong of a resource as it could be in helping agencies address volunteer recruitment and other challenges or helping to communicate agencies' needs to policymakers. The bureau should improve performance data tracking and remove barriers to data reporting.

The Legislature could support agency recruitment and retention efforts by providing financial compensation, benefits, and training.

Under the status quo, the bureau is limited in the amount of technical assistance and oversight it can provide, many agencies are struggling to staff a 24-hour, 7-day-a-week operation, and Idaho has inconsistent EMS. The bureau and agencies reported that funding is a significant limiting factor they face to address these challenges.

In our 2010 evaluation of EMS, we recommended that the state fund agencies based on the cost of readiness. The state has not adopted this recommendation. However, the state could take a different approach by providing targeted support to address recruitment and retention challenges. The Legislature could assist agencies by providing financial compensation for volunteers, expanding employee benefits to include volunteers, and supporting EMS training.

Recommendations and policy considerations are discussed in chapter 5.

The bureau and agencies reported that funding is a significant limiting factor they face to address challenges.

1

Introduction

Background

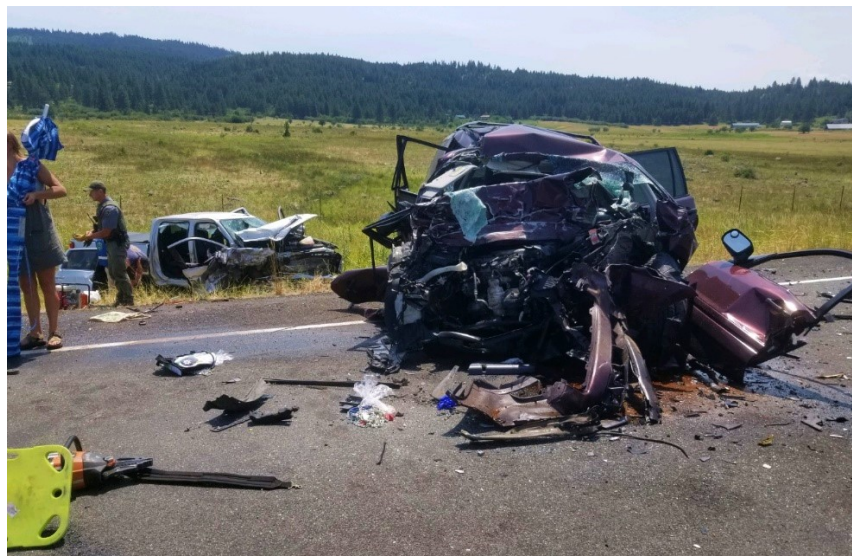
No one wants to find themselves in an emergency and needing medical care. Idaho Administrative Code defines an emergency as the sudden onset of a medical condition so severe that a prudent layperson could expect the absence of immediate medical attention to

place the person's health in serious jeopardy;

cause serious impairments of bodily function; or

cause serious dysfunction of bodily organs or parts.¹

Emergency medical services (EMS) provide out-of-hospital acute care and transport. In general, state and local organizations manage the development, funding, and maintenance of EMS. Like other states, Idaho has relied on volunteers to help staff EMS, especially in rural areas. Idaho EMS agencies reported being dispatched to more than 146,000 emergency calls in 2020.



Source: Syringa Hospital.

Legislative interest

In our 2010 evaluation, *Governance of EMS Agencies in Idaho*, we found that Idaho's system was fragmented and built on a statutory framework that had not kept pace with the evolution of EMS. The Department of Health and Welfare's 2018 *Town Hall Meeting Report* described that EMS stakeholders across the state had concerns about volunteer recruitment and retention. The Joint Legislative Oversight Committee approved a request during the 2021 legislative session asking us to evaluate any improvements to EMS administration and examine policies to address challenges in recruitment and retention of EMS volunteers.

Eight legislators submitted the request, expressing concern over increasing pressure on EMS due to demographic changes. The request stated that agencies were "scrambling every year" to secure funding for growing EMS needs. The evaluation request is in appendix A.

Evaluation approach

The evaluation request asked that we update our previous findings related to EMS governance, explore staffing issues, and propose solutions to improve recruitment and retention. We also examined agency funding to better understand reliance on volunteer staff.

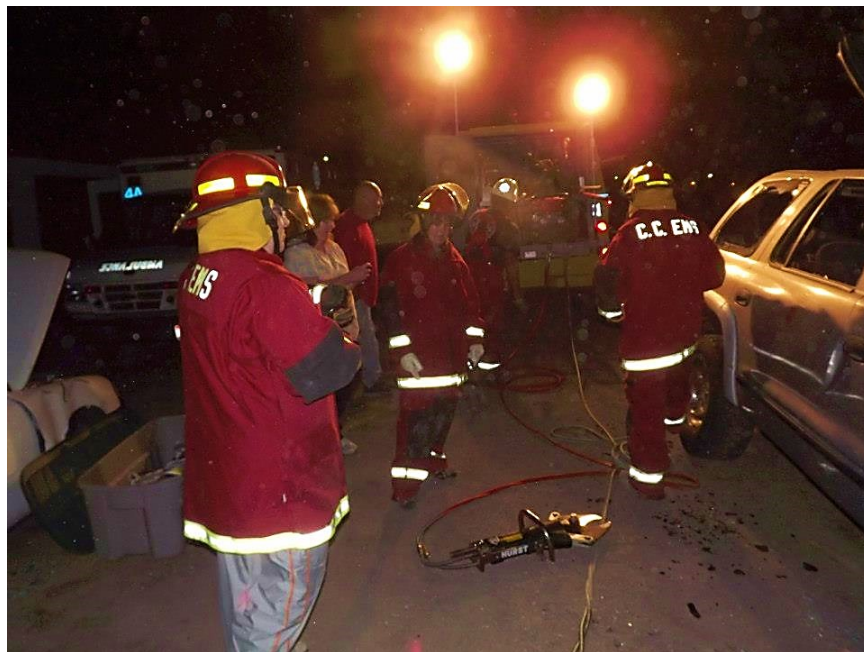
EMS is administered by different types of agencies that sometimes provide other services. Services outside of EMS, such as fire protection, involve separate governance structures and stakeholders. Should legislators wish to learn more about governance of fire protection services and efforts to improve recruitment of firefighters, OPE could pursue this information through a separate evaluation. See appendix B for our evaluation scope and appendix C for our methodology.

2

Governance

The federal government launched an initiative 50 years ago that provided funding for states to create local EMS governance systems. Federal support has since diminished, leading local systems to pursue other resources or dissolve. In our 2010 evaluation, we found fragmented service provision and recommended statute to establish regional or county-level systems. Although we found in our 2013 follow-up evaluation that some agencies had developed new partnerships, our recommendations remained largely unaddressed.

Idaho still does not have a statewide structure for collaborative governance. The Department of Health and Welfare's Bureau of EMS and Preparedness reported that it has limited authority and capacity to expand its support of EMS agencies.



Source: Caribou County EMS.

Idaho Code does not require EMS.

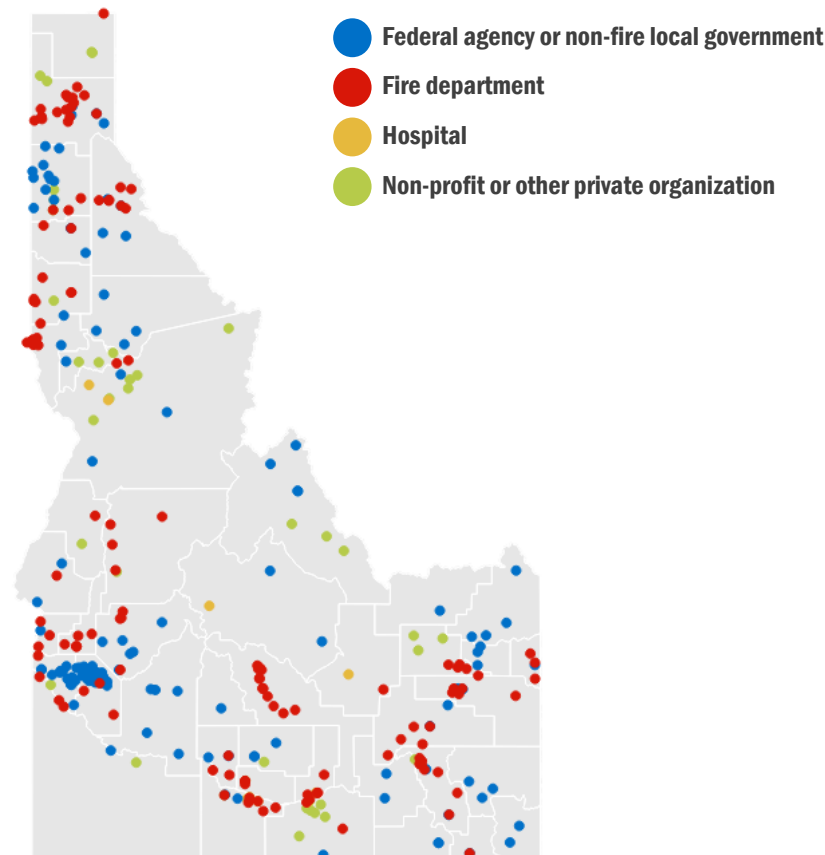
Idaho does not designate EMS as an essential government service and therefore does not guarantee access for all Idahoans. Idaho Code authorizes, but does not require, counties to establish ambulance services where they are not reasonably available. EMS is an essential government service in nine states. For example, in 2021 the Utah Legislature required all municipalities and counties to ensure access to 911 ambulance services.

EMS is administered by a complex network of agencies, including private entities, non-profit organizations, and local governments, such as cities, counties, and fire departments. Over half of EMS staff work at agencies that respond to fires. Exhibit 1 displays current agency station locations.

Exhibit 1

EMS is administered by different types of organizations.

Stations by organization type in 2021.



Note: Station locations do not represent access to EMS (see chapter 4).

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

EMS is usually housed in local governments, such as cities and counties.

In 2021, the bureau licensed 185 agencies, including 31 entities that operated under shared licenses.

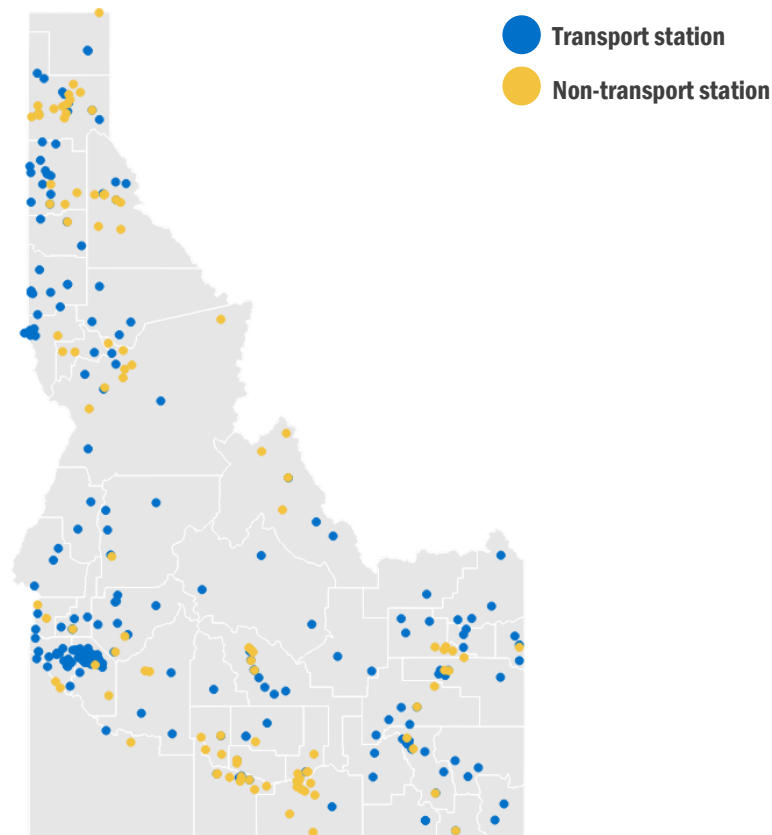
“ If you’ve seen one EMS agency, you’ve seen one EMS agency. – EMS agency official in Bannock County

In 2021, the bureau licensed 185 agencies, including 31 entities that operated under shared licenses. Over half were transport agencies that operate ambulances or air medical units. Primary transport agencies are ambulances with primary responsibility for responding to calls in their service area. Other transport agencies assist primary transport agencies with specialized services, such as air transport. Non-transport agencies, called quick response units, also assist primary transport agencies by arriving first on the scene to evaluate patients in remote areas (see exhibit 2).

Exhibit 2

Quick response units and transport agencies often work together to provide EMS.

Transport and quick response (non-transport) stations in 2021.



Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

Little progress has been made on our 2010 recommendations.

In our 2010 evaluation, we found that statute did not designate a governing body with the authority to limit service duplication, require statewide coverage, or mandate cooperation among agencies. These findings have not changed (see exhibit 3).

Exhibit 3

No statutory changes have been made to address our 2010 findings and recommendations.

List of our 2010 findings and recommendations and their current status.

| 2010 Findings and recommendations | Current status |
|---|--|
| Idaho Code did not designate EMS as an essential service, guarantee access to all Idahoans, or require agency coordination. The bureau used an agency maturity rating, which found that most agencies operated independently. Recommendation: Create a structure for local-level governance that designates systems by county boundaries. | No change. Some agencies have started to collaborate more on their own but statute still does not ensure regionalized EMS systems. |
| Idaho Code did not empower the bureau to hold agencies accountable for many performance outcomes or guarantee service coverage. Recommendation: Increase the role of the bureau. | No change. |
| Idaho Code did not authorize the appointment of a state medical director who could assist agency medical directors. Recommendation: Create regional medical oversight to support agency medical directors and consider a state medical director. | No change. |
| EMS was not funded based on the cost of readiness. Recommendation: Consider reviewing funding structure and require local systems to create comprehensive EMS plans that address funding. | No change. See chapter 3 for the current status of EMS funding. |
| The National Highway Traffic Safety Administration recommends system assessments every 3-5 years. Idaho's last assessment had been done 17 years prior to our 2010 evaluation. Recommendation: Request a new system assessment. | No change. Idaho's last assessment was in 1993. |

Source: Office of Performance Evaluations' analysis of Idaho Code and stakeholder interviews.

The bureau made several rule changes with the goal of making it easier for agencies to meet standards.

The bureau removed rules governing the EMS Advisory Committee.

Rule changes

Although little progress has been made on our 2010 recommendations, the bureau implemented several rule changes, such as lowering requirements for staffing and operations with the goal of making it easier for agencies to meet standards. Rule changes include

- decreasing minimum requirements for being the care provider on an ambulance or air medical unit from Emergency Medical Technicians (EMTs) to Emergency Medical Responders (EMRs) with an ambulance certification;

- allowing Advanced Emergency Medical Technicians (AEMTs) licensed under old standards to pursue optional training modules to get closer to current standards without going through the full training and certification process required of new applicants (see appendix D);

- making agency protocols for the administration of education programs less strict;

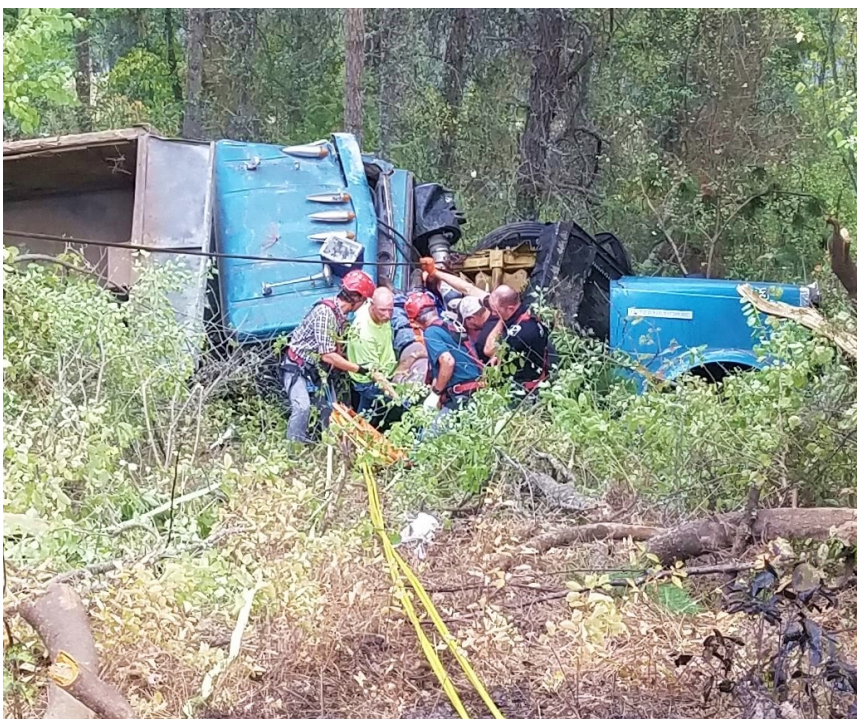
- creating a ground EMS agency licensure option for hospitals, allowing them to incorporate paramedics into their emergency departments in response to staffing shortages; and

- joining the Recognition of EMS Personnel Licensure Interstate CompAct, which allows providers to practice across multiple states using their home state licenses.

In 2022, the bureau will also pursue changes that would remove some clauses describing the bureau's regulation of education and reduce the amount of documentation agencies must submit to the bureau. The bureau reported that it plans to remove all non-regulatory information from Idaho Administrative Code in accordance with the Governor's Red Tape Reduction Act.

As part of this initiative, sections concerning the vehicle and equipment grant and the EMS Advisory Committee were completely removed in 2020. Idaho Code still outlines the major goals of the vehicle and equipment grant but does not reference the advisory committee. The bureau coordinates with the advisory committee and other representative bodies to govern EMS (see appendix E).

Administrative Code used to outline the appointment and service of committee members and specific roles that the committee plays for the bureau. According to the bureau, the removed rules still serve as the foundation for committee management. However, the bureau does not have written internal policies about advisory committee membership and responsibilities.



Source: Syringa Hospital.

The bureau reported concerns that enforcing some licensure requirements would leave areas without EMS.

Narrow statutory authority and staffing pose challenges for the bureau.

In our 2010 evaluation, we recommended that the Legislature increase the bureau's role in governing EMS. In this evaluation, the bureau reported that it has limited authority and capacity to expand its support of EMS agencies.

Bureau authority

The bureau operates primarily as a regulatory body. As no statutory requirement exists for providing EMS, the bureau is not empowered to ensure that the entire state is covered by an agency. The bureau can revoke licenses of agencies that do not meet existing requirements but reported concerns that doing so would leave areas without EMS.

Although agency officials we interviewed also noted this concern, some reported that the bureau's limited authority and hesitancy to enforce existing licensure requirements, in particular the response requirement, act as barriers to improving EMS standards. Others reported that Idaho's response time standards are already lower than some other states. The bureau reported that some neighboring states have response time standards similar to Idaho.

The bureau does not formally track mutual aid or other cooperative agreements between agencies. In our 2010 evaluation, we recommended legislation to create regional or county-level EMS systems. Although the bureau reported that it encourages agencies to develop their own systems, it does not have a mechanism to facilitate ongoing coordination between agencies in each region. By the request of an agency director or elected official, the bureau has worked directly with some agencies to diagnose issues and prescribe solutions. Although many agency directors reported good working relationships with the bureau, several called for the bureau to play a more active role in developing agency collaboration and establishing an effective statewide system.

“ There is not comprehensive enabling legislation to allow the bureau to do what they need to do. — Official with the EMS Physician Commission

Bureau staffing

The bureau no longer has regional offices. Many agency directors reported that consolidating offices to Boise made the bureau less responsive to rural needs. The bureau reported that closing the regional offices increased efficiency and avoided potential conflicts of interest that could have arisen between regional staff and the agencies they regulate. Bureau officials are beginning to explore whether housing EMS in regional public health districts or healthcare coalitions may address concerns raised by rural agencies.

During our interviews, several agency officials also reported that turnover at the bureau was a barrier to effective communication. The bureau has seven full-time positions dedicated to EMS. These positions have experienced 29 instances of turnover since 2010. Additional staff have responsibilities related to the bureau's other work but dedicate a share of their time to EMS. The bureau estimated that the equivalent of 10.6 other full-time positions, including contractors, support EMS. The bureau has tried to address turnover by moving site visits to a contracting model, which splits the necessary travel for positions across more people.

Many agency directors reported that consolidating offices to Boise made the bureau less responsive to rural needs.

Time Sensitive Emergency System Council

Idaho Code § 56-1028 states that one of the duties of the Time Sensitive Emergency System Council is to “collaborate and cooperate with the EMS bureau, the EMS Physician Commission, local governments, local EMS agencies and associations to address recruitment and retention concerns of local EMS providers.” We found little awareness of this responsibility. See appendix E for more information on representative bodies that work with the bureau to govern EMS.



Idaho still does not have a statewide structure for collaborative governance of EMS.

36% of agencies reported being part of a formal partnership.

Agency-led coordination does not create a statewide EMS system.

Collaboration can decrease tension between fire and EMS departments, save agencies money, and increase agency capacity to manage data. In rural areas, service coverage depends on coordination, as agencies must work together to ensure that all calls receive a response. In urban areas, collaboration helps avoid service duplication. Agency officials reported a willingness to collaborate, however Idaho still does not have a statewide structure for collaborative governance.

Barriers to coordination

We asked agency directors in our interviews about barriers to coordination. Reported factors that affect coordination include

- staff turnover at agencies, especially ones that rely on volunteers, as institutional knowledge can be lost in staff transitions;

- the geography and distance between agencies, especially rural ones;

- agency models, as directors reported that fire-based agencies are more likely to collaborate with one another than other types of agencies; and

- personality issues between agency leaders that can prevent them from forming partnerships and maintaining collaborative agreements over time.

Agency-level partnerships

In spite of these barriers, some agencies have been able to develop partnerships. We surveyed agency directors in Idaho to learn more about their perspective on collaboration and other issues. Of agency directors who responded to our survey, only 36 percent reported being part of a formal partnership to increase service coverage, minimize resource duplication, or provide consistent standards of care.

Some agencies have licensed jointly through the bureau (see exhibit 4). One agency director raised concerns that without legislation mandating coordination, there is no guarantee that current partnerships will continue.

Exhibit 4

31 agencies operated under joint licenses to provide EMS.

List of agencies operating jointly under single licenses in 2021.

| Ada County-City Emergency Services System | Treasure Valley EMS System | Kootenai County EMS System | Bannock County Ambulance | Lemhi County EMS System |
|--|-----------------------------------|---|---------------------------------|----------------------------------|
| Ada County Paramedics | Canyon County Paramedics | Coeur d'Alene Fire Department | Pocatello Fire Department | Salmon EMT |
| Boise Fire Department | Nampa Fire Department | Kootenai County Fire and Rescue | Inkom Ambulance | Leadore EMT |
| Eagle Fire Department | Caldwell Fire Department | Northern Lakes Fire Protection District | Downey Ambulance | Salmon Search and Rescue |
| Kuna Fire District | Middleton Fire Department | Spirit Lake Fire Protection District | Lava Hot Springs Ambulance | Eld Bend Quick Response Unit |
| Meridian Fire Department | Melba Quick Response Unit | Timberlake Fire Protection District | | Gibbonsville Quick Response Unit |
| North Ada County Fire Rescue District | Wilder Fire Department | Worley Fire Protection District | | |
| Star Fire District | | Hauser Lake Fire Protection District | | |
| | | Mica Kidd Island Fire Protection District | | |
| | | East Side Fire Protection District | | |

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

3

Funding

“ Our agency averages 350 calls a year. That would be an average of one a day, but that’s not how it actually works. We go two weeks without an ambulance moving, and then one day we have eight calls. – EMS agency official in Caribou County

EMS expenses include the direct cost of each emergency response and ongoing overhead to keep the operation ready to respond 24 hours a day, 7 days a week. In our 2010 report, we found that the state did not follow nationally recommended practices for funding EMS. Idaho still does not have a formula to determine the cost of readiness and ensure EMS agencies are funded accordingly. Agencies rely on different funding models and a patchwork of funding sources.



Source: Caribou County EMS.

Most agencies reported having insufficient funding to meet the emergency medical care needs of their communities.

EMS needs vary greatly and so do associated costs. Providing a diabetic person with insulin treatment on site in Meridian would likely cost significantly less than providing air transport from Clearwater National Forest to the nearest hospital for someone who has been in a car accident. Funding also varies greatly. Agencies have access to different funding sources and amounts depending on organization type, services provided, patient health insurance, and other factors.

The federal government has little information about EMS agency funding and costs. The US Government Accountability Office surveyed Medicare-eligible EMS providers in 2012 and found that the average ground emergency transport cost ranged from \$224 to \$2,204 depending on services provided.² However, the survey sample was small and did not include hospitals or fire departments that provide EMS. Costs would also likely vary more widely when incorporating non-transport services and air transport services. In 2018, a report commissioned by the US Department of Health and Human Services pointed out some of these data shortcomings and identified several challenges to evaluating whether agencies can cover their costs.³ Although federal improvement efforts are underway, no comprehensive national data on funding EMS agencies exists.

The state also has little information about agency funding and costs. While local tax districts that fund EMS must provide approved budgets to the Legislative Services Office, this data is not uniform or specific and does not provide information at the agency level.

The state has little information about EMS agency funding and costs.

2. GAO-13-6, *Costs and Medicare Margins Vary Widely; Transport of Beneficiaries Have Increased*, U.S. GOV'T ACCOUNTABILITY OFF. (2012), <https://www.gao.gov/assets/gao-13-6.pdf>.

3. Andrew Mulcahy et al., *Medicare's ground ambulance data collection system: sampling and instrument considerations and recommendations*, CTR. FOR MEDICARE AND MEDICAID SERV. (2019), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Ground-Ambulance-Data-Collection-System-Sampling-Instrument-Considerations-Recommendations.pdf>.

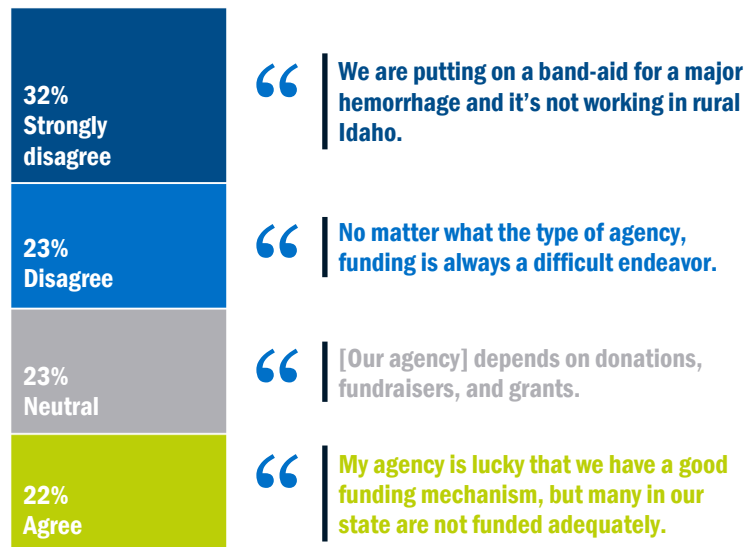
The bureau does not require financial information to maintain agency licensure and only receives high-level budget reports from certain agencies if they apply for grants. Bureau officials reported that if they requested more financial information from agencies, the data would likely not be uniform or specific. Rural agencies with fewer resources struggled to provide our office with detailed financial information because more affordable billing systems are not searchable by payer type or other factors.

Our survey provided some insight on EMS funding according to agency directors across the state. More than half of agency directors reported that they did not have sufficient funding to meet the emergency medical care needs of their community (see exhibit 5).

Exhibit 5

22% of directors reported that their agency receives sufficient funding.

EMS agency director agreement with the statement: My agency receives sufficient funding to consistently provide the amount and quality of emergency medical care that our community needs.



Note: No agency directors strongly agreed with this statement.

Source: Office of Performance Evaluations' survey of EMS agency directors.

EMS agencies face challenges in recuperating costs through billing.

EMS is nearly universally delivered without requiring proof of insurance or ability to pay. After services are rendered, agencies often bill patients or their health insurance directly. Medical billing is complicated. Some agencies without sufficient staff capacity contract with companies to provide billing services.

Varied staff capacity and resources for billing systems limit knowledge about the scale of financial shortfalls reported by agencies. Agencies reported that in many cases they cannot cover their costs through billing because

reimbursement rates are low;

some on-site treatment does not qualify for reimbursement; and

some treated patients do not have health insurance or the financial resources to pay.

Low reimbursement rates

Private and public health insurance reimburse some costs related to EMS. Despite limited data, national experts, including the National Highway Traffic Safety Administration's National EMS Advisory Council, have consistently reported that reimbursement rates are lower than the cost of services provided.⁴

Our interviews with agencies in Idaho supported the conclusion that neither public nor private health insurance fully reimburse for the cost of services provided. Agencies with more sophisticated billing software were able to provide additional context about their experience. For example, Ada County Paramedics reported that it lost \$520 per Medicare patient and \$550 per Medicaid patient treated and transported to a hospital in county fiscal year 2020.

4. *EMS system performance-based funding and reimbursement model*, NAT'L EMERGENCY MEDICAL SERV. ADVISORY COUNCIL (2019) Revised, https://www.ems.gov/NEMSAC-advisories-and-recommendations/2016/NEMSAC_Final_Advisory_EMS_System_Funding_Reimbursement.pdf.

EMS is nearly universally delivered without requiring proof of insurance or ability to pay.

Quick response units in rural areas are most affected by limited reimbursement for care provided on site.

The state does not control Medicare reimbursement, but it has some discretion over Medicaid reimbursement because the program is jointly administered by the state and federal government. The Idaho Fire Chiefs Association has advocated for the state to pursue a Medicaid plan amendment for supplemental reimbursement of Ground Emergency Medical Transportation (GEMT). A GEMT state plan amendment would allow agencies to have their reimbursement be calculated based on a share of their actual costs rather than based on a cost survey of all providers. States including Colorado, Missouri, Nevada, and Washington have a GEMT plan amendment.

On-site care rarely reimbursed

An ambulance generally must transport the patient to a hospital emergency department to receive funding from Medicare and private health insurance companies. Agencies often cannot receive any reimbursement for responding and evaluating patients at the scene. Quick response units in rural areas are most affected by limited reimbursement for care provided on site because they do not provide transport services.

The federal government has noted the potential cost savings and benefits of providing treatment on site and at locations other than the emergency department, such as urgent care centers. Medicare temporarily increased flexibility about where eligible care is provided to decrease pressure on hospital emergency departments during the COVID-19 pandemic. In 2019, Medicare also launched a pilot program that allows reimbursement for EMS at non-hospital locations. Awareness of the pilot program was limited among officials with the bureau and no agencies in Idaho participated. Very few agency directors we spoke with were aware of either the pilot program or increased flexibility in eligible care locations during the pandemic.

Idaho Medicaid does reimburse transport agencies for response, evaluation, and on-site treatment even when the patient does not need to be taken to the hospital afterwards. Quick response units, which only provide on-site treatment, are not eligible for this reimbursement either though. Many agencies were unaware that Idaho Medicaid reimburses transport agencies for on-site treatment. In 2020, just 31 agencies received reimbursement for patients that did not require transportation to the hospital. Agencies that did bill Medicaid reported that the reimbursement rate for on-site treatment does not cover their average cost.

Lack of health insurance and financial resources

EMS use is higher among lower-income and uninsured people because they have difficulty accessing routine medical care.⁵ We do not yet know the effect of expanding access to Medicaid in Idaho because the COVID-19 pandemic delayed the release of health insurance estimates from the first full year of expansion. The pandemic also likely affected private health insurance coverage through employers. According to our analysis of 2019 US Census Bureau data, about 1 in 8 Idahoans under 65 years old did not have health insurance. Agencies in rural counties are most affected by lack of health coverage because their uninsured rates are consistently higher than the state average. More than 1 in 7 rural Idahoans lacked health insurance in 2019.



Source: Moscow Volunteer Fire Department.

Rural Idahoans are more likely to be uninsured than urban Idahoans, making it harder for rural EMS agencies to recover their costs.

5. Zachary F. Meisel et al., *Variations in ambulance use in the United States: the role of health insurance*, 18 ACADEMIC EMERGENCY MEDICINE n. 10 1036--44 (2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196627/>.

EMS agencies have little flexibility to cover staffing costs through state and local revenue sources.

EMS agencies must pay for unreimbursed care to stay financially solvent and not affect services for their community. Some agencies in Idaho can offset these costs with revenue from property taxes and certain fees related to driving and new property development.

Comparing Idaho's funding to other states is challenging because EMS is administered and funded differently across the country. State and local governments rely on a combination of property, sales, and income taxes to help fund EMS, in addition to various fees and fines. Patient EMS needs and geographical landscape vary across the country. Since health insurance coverage varies too, some agencies may need more tax revenue than others because they are less able to get reimbursement for their services.

Although some agencies in Idaho reported sufficient revenue for capital improvement, vehicles, and equipment, many agencies reported increasingly limited options to raise revenue for staffing, especially in rural areas.

Funding for capital improvement, vehicles, and equipment

Some agencies can offset their unreimbursed costs through impact fees and driver's license fees, but only if the funds go toward capital improvement, vehicles, and equipment.

Impact fees

Certain tax districts that fund EMS are allowed to seek authorization from cities and counties to collect impact fees from new development.⁶ Fire protection districts have been able to pursue impact fees since 2007. In 2021, the Legislature extended this right to ambulance service districts through House Bill 110. Any impact fees collected must go towards capital improvement and may not be used for ongoing operations costs, such as paying staff.

6. IDAHO CODE § 67-8204(A), (2021), <https://legislature.idaho.gov/statutesrules/idstat/Title67/T67CH82/SECT67-8204/>.

Driver's license fees

The bureau receives \$1.50 annually per standard driver's license issued, \$1 of which is distributed to nonprofit and governmental EMS agencies through a vehicle and equipment grant.⁷ In our 2010 evaluation, we recommended that the Legislature consider broadening allowable uses for the grant and increasing the amount dedicated to EMS from driver's license fees. The grant has funded 36 response vehicles and 989 pieces of equipment since state fiscal year 2017.

Agencies requested \$4.3 million for vehicles and equipment in state fiscal year 2021, far exceeding the \$1.7 million available in grant funding. Unmet demand may be higher though. The grant only covers a portion of the full cost of vehicles and equipment. In our interviews, we found that this may lead some agencies with insufficient funding not to apply for the grant because they must come up with a way to cover the rest of the costs on their own. Volunteer-led agencies also may struggle with staffing to apply for grants (see chapter 4).

Agencies reported that this funding was a critical resource for their operations. The EMS Advisory Committee noted that the driver's license EMS fee has not increased since the grant fund was created in 1999. If the fee had kept up with inflation, the grant would have received 66 percent more funding per license issued.

Funding for staff

Some agencies can offset unreimbursed costs with revenue passed through their local tax districts from motor vehicle registration fees, property taxes, and state revenue sharing. Revenue from these sources can be used for any EMS operations, including staffing costs.

Motor vehicle registration fees

Some agencies receive motor vehicle registration fee revenue through counties.⁸ Counties have discretion in distributing motor vehicle registration revenue as long as the funding goes toward EMS. In our 2010 evaluation, we recommended that the Legislature consider increasing the amount dedicated to EMS from motor vehicle registrations.

7. IDAHO CODE § 49-306(9)(a), (2021), <https://legislature.idaho.gov/statutesrules/idstat/title49/t49ch3/sect49-306/>.

8. IDAHO CODE § 49-452, (2021), <https://legislature.idaho.gov/statutesrules/idstat/Title49/T49CH4/SECT49-452/>.

Demand was more than double the available funding for the EMS vehicle and equipment grant in 2021.

Twenty-five cents of each annual registration fee goes to the county for local EMS costs and \$1 goes to the bureau. Statewide about \$488,000 was distributed to counties in state fiscal year 2021, ranging from less than \$500 in Camas County to about \$120,500 in Ada County. The motor vehicle registration fee has not increased since 1990. Funding for EMS agencies from their counties would have more than doubled for each vehicle registered if the fee had kept up with inflation.

Property taxes

Some property tax funding can be used by agencies for EMS. Agencies may receive property tax revenue through their county, city, hospital district, fire protection district, or ambulance service district. Property taxes have statutory restrictions intended to suppress tax growth, as discussed in the next section.

Federal funding in response to COVID-19

The federal government provided EMS funding to help manage increased costs due to the COVID-19 pandemic. Agencies reported that COVID funds helped them cover the immediate increase in demand and make some overdue investments in equipment. However, the funds were short-term and did not address ongoing costs related to operations, including staffing. The Governor's Coronavirus Financial Advisory Committee has been working with the Controller's Office to collect and share information on COVID-related expenditures. Funding went to several different types of entities that provide EMS, however the state has not been tracking how much of that funding goes to EMS specifically rather than other types of services related to COVID. For example, the share of COVID funding related to EMS is not available for counties, cities, fire departments, or hospitals. Data limitations also did not allow us to determine which agencies received funding from tax districts related to EMS.



EMS agencies are limited in their ability to cover remaining costs through property taxes.

Ambulance service districts and fire protection districts can be created through a county-wide election. Both districts are governed by their own elected board of commissioners. Ambulance service districts may levy up to 0.04 percent of the assessed market value for maintenance and operations levies. Fire protection districts may levy up to 0.24 percent of the assessed market value for maintenance and operations levies. Districts do not necessarily levy the maximum rate. Rather, districts set their levy rates when they are created based on service costs at the time.

Most counties that wish to have a dedicated levy for EMS must create a separate ambulance service district. However, 16 counties may levy their own ambulance service fund of up to 0.02 percent of assessed market value. In 2019, half of these counties used their ambulance service fund. All of the counties that did not use their service funds had an ambulance service district, fire protection district, or both. Clark County was the only county relying solely on the ambulance service fund for dedicated EMS property tax revenue.

Counties, cities, and hospital districts may use general fund revenue from property taxes toward EMS. General funds offer the tax district flexibility but also compete with the budgetary needs of other community services, such as law enforcement and court operations.

Maintenance and operations levies for tax districts that fund EMS are subject to a 3 percent budget cap. Districts may only increase their total budget by up to 3 percent higher than the largest budget they had over the prior 3 years. This cap applies to maintenance and operations levies regardless of whether a district is at their maximum levy rate.

Agencies still do not know the full effect of House Bill 389, which made several property tax changes in 2021. For example, Kootenai County EMS planned on purchasing an additional ambulance and hiring staff to meet community needs in the spring of 2021 but delayed the expansion due to funding uncertainty. House Bill 389 limited the ability of tax districts to account for increased service costs in their budgets. Agency

Many rural agencies reported trying to collect donations from community members and local businesses to cover their costs.

officials reported that they expect to receive less revenue than they otherwise would have because the budget cap no longer fully accounts for growth in service use due to new construction and annexation.

Reimbursement rules were different when the 3 percent budget cap was created in 1995. For example, the federal government no longer allows agencies to bill patients directly for all costs not reimbursed by Medicare. Agency directors reported that they are more dependent on property taxes now than they were when the budget cap was implemented.

We analyzed property tax budgets from the Tax Commission to learn more about ambulance service and fire protection district funding. Our analysis focused on 2019, before the COVID-19 pandemic affected the cost of services and provisions of House Bill 389 were in effect.

Only one ambulance service district taxed the maximum levy rate of 0.04 percent, and no fire protection districts taxed the maximum levy rate of 0.24 percent. The budget cap constrained 14 out of 28 ambulance service districts and 90 out of 158 fire protection districts in 2019. In total, more than half of ambulance service and fire protection districts were restricted in their ability to cover any remaining unreimbursed costs through property taxes (see exhibit 6).

Exhibit 6

Most ambulance service and fire protection districts were at their property tax budget limit.

Share of ambulance service and fire protection districts at their maximum taxing capacity, using the full 3 percent allowable budget increases in 2019.



50% of ambulance service districts were constrained by the budget cap.



57% of fire protection districts were constrained by the budget cap.

Source: Office of Performance Evaluations' analysis of data from the Tax Commission.

Many more districts were almost at their budget cap. Nearly 86 percent of ambulance service districts and 90 percent of fire protection districts were at 95 percent of their maximum taxing capacity. See appendix C for more information on our methodology.

Districts could ask voters to raise property taxes past the 3 percent budget cap. However, many agencies reported that their community cannot afford a property tax increase. Agencies reported that commissioners risk losing their elected positions by trying to raise property taxes. The ambulance service or fire protection taxing district could be dissolved entirely. If a community does lose its ambulance service or fire protection district, recent legislation would make annexation into another district less financially viable.

“ It’s really hard trying to convince people who have never had a heart attack or a stroke why EMS is important. – EMS agency official in Kootenai County

Agencies could increase service fees and more aggressively go after outstanding bills to recover costs, but officials reported being fearful that people would no longer call 911 when they need help. Instead, when agencies struggle financially, they often end up asking more from existing staff and trying to find people who are willing to provide emergency medical care for their communities without compensation.

“ The last thing we’re going to do is scare people into not calling 911 for an ambulance because they think we’re a bill collector. – EMS agency official in Latah County

Many agencies reported that their community cannot afford a property tax increase to fund EMS.

4

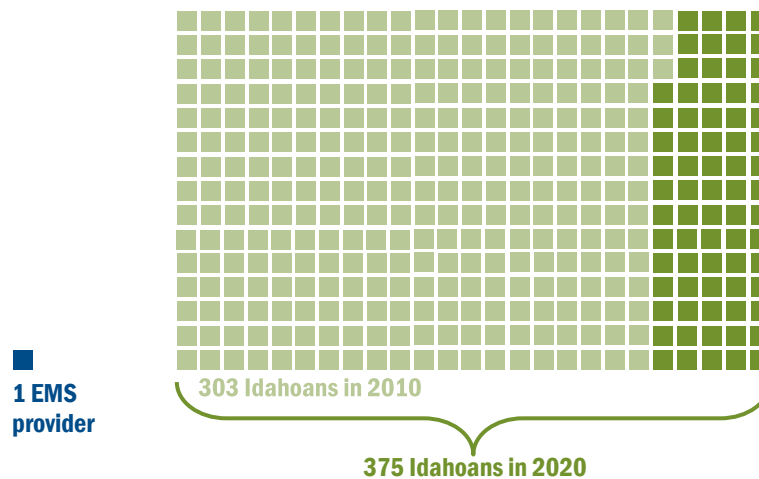
Staffing with volunteers

Although all states have some EMS volunteers, academic research suggests that Idaho relies more on volunteers than 40 other states.⁹ EMS agency officials reported long-standing challenges in recruiting and retaining volunteers. Idaho has also been among the fastest growing states in recent years, increasing pressure on emergency response systems. Some agencies have been able to raise enough revenue to hire paid EMS providers while others have not. The number of Idahoans per licensed EMS provider increased 24 percent from 2010 to 2020 (see exhibit 7).

Exhibit 7

The number of EMS providers has not kept up with population growth in Idaho.

Idahoans per EMS provider in 2010 and 2020.



Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare, the Department of Labor, and the US Census Bureau.

9. Rebecca E. Cash et al., *Comparison of volunteer and paid EMS professionals in the United States*, 25 PREHOSPITAL EMERGENCY CARE 205-12 (2021), <https://pubmed.ncbi.nlm.nih.gov/32271639/>.

Many agencies reported having insufficient staff to meet the needs of their communities.

Stakeholders reported that recruiting and retaining sufficient staff is one of the biggest challenges for EMS in Idaho. The bureau does not have a formula to determine the number of needed staff at agencies, nor does it require agencies to track the number of needed staff. Just 18 percent of agency directors who responded to our survey reported being able to maintain sufficient staff to meet the needs of their community (see exhibit 8).

Exhibit 8

18% of directors reported that their agency is able to maintain sufficient staff.

EMS agency director agreement with the statement: My agency is able to maintain sufficient staff and volunteers to consistently provide the amount and quality of emergency medical care that our community needs.



Source: Office of Performance Evaluations' survey of EMS agency directors.

Stakeholders reported that recruiting and retaining sufficient staff is one of the biggest challenges for EMS in Idaho.

Reliability of volunteers is a challenge as their jobs, family, and other obligations often take priority.

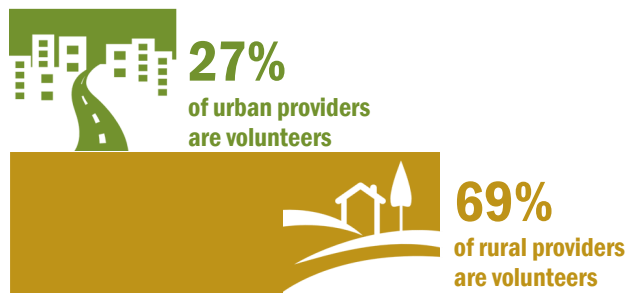
Most EMS providers in rural Idaho are volunteers.

Idaho has nearly 2,000 EMS volunteers, making up about just over 40 percent of EMS providers statewide. The EMS agency directors we interviewed in urban areas generally reported being more sufficiently funded than their more rural peers. Agencies in Idaho's urban areas are less likely to rely on volunteers to meet their emergency response obligations (see exhibit 9).

Exhibit 9

Rural agencies rely more on volunteers to staff EMS than urban agencies.

Share of EMS providers who are volunteers by county rurality in 2021.



Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare and the US Census Bureau.

Agency officials reported that when providers retire, they are no longer being replaced by as many volunteers from the next generation. The pool of younger residents who could replace existing volunteers is shrinking in rural areas that need them most. The Department of Labor reported that although populations over 55 have been growing in every county, rural counties have seen a population decline among people under 55.

We asked agency directors to rank 12 barriers to recruitment and retention identified through our literature review (see exhibit 10). Reliability of volunteers is a challenge. Their jobs, family, and other obligations often take priority. Agency directors we surveyed reported that on average just 60 percent of their volunteers can be counted on to respond to a call when on duty.

“ Emergencies don’t happen at convenient times. – EMS agency official in Bingham County

Staffing with volunteers during traditional work hours is particularly difficult as many employers do not allow employees to leave work and respond to an emergency call. We also heard from stakeholders that younger rural residents are more frequently commuting to larger cities for work. The longer commute places them out of on-call range. Rural agencies also sometimes lose their volunteers to nearby larger cities that can afford to pay staff.

Outside of being on call for an emergency, volunteers often must invest additional time and money because of required background checks, initial training, exams, and continuing education (see appendix D). When there are not enough EMS providers, agencies ask for more time from remaining volunteers – resulting in burnout.

Exhibit 10

EMS agency directors reported several factors that work against their recruitment and retention efforts.

Top six barriers to recruitment and retention of volunteers according to EMS agency directors.

- 1 Community members don’t have time or are not interested in volunteering
- 2 Lack of compensation
- 3 Training and licensure requirements are too long or intensive
- 4 Employers are not flexible in allowing staff to fulfill volunteer commitments
- 5 Lack of benefits
- 6 Burnout from too many calls

Source: Office of Performance Evaluations' survey of EMS agency directors.

When possible, agencies try to find ways to shift resources so that they can compensate volunteers. Some agencies reported that they provide nominal compensation, such as paying volunteers about \$30 for a 24-hour shift plus an additional \$25 when they are called out to an emergency. Just over 55 percent of volunteers are nominally compensated. However, some agencies cannot afford to provide monetary compensation to volunteers. About 45 percent of volunteers do not receive any payment for their work.

Effect of COVID-19 on EMS staffing

During the pandemic, EMS officials reported that agencies collaborated to assist with staffing. However, officials also reported that many volunteers quit due to the risk of COVID exposure. EMS volunteers who qualify for worker's compensation receive either the average weekly wage of their regular employment or 67 percent of the average weekly wage in Idaho, whichever is higher. Agency officials reported that this coverage is not adequate to support volunteers injured on the job, especially since agencies may not offer health insurance to volunteers.



Inadequate EMS staffing affects patient care.

Agency officials we interviewed consistently reported that not every Idahoan gets the level of care they need during an emergency. Insufficient staffing was the primary reason cited in our interviews.

Less advanced training

The bureau licenses four levels of EMS professionals: emergency medical responder (EMR), emergency medical technician (EMT), advanced emergency medical technician (AEMT), and paramedic (see exhibit 11). Each type of EMS license requires different training and allows a professional to operate under a certain scope of practice, which affects the level of care a person can receive in an emergency.

Exhibit 11

Each type of EMS license allows a professional to provide a different level of life support.

Provision of medical care by provider licensure level.

| | Basic life support | Intermediate life support | Advanced life support |
|--|--------------------|---------------------------|-----------------------|
| Emergency Medical Responder (EMR) | ✓ | | |
| Emergency Medical Technician (EMT) | ✓ | | |
| Advanced Emergency Medical Technician (AEMT) | | ✓ | |
| Paramedic | | | ✓ |

Notes: The bureau has allowed providers to maintain AEMT licensure even though standards have risen for newly licensed providers. As a result, EMS medical experts reported that some agencies are effectively providing basic life support though they may be categorized by the bureau as providing intermediate life support.

Source: Office of Performance Evaluations' analysis of Idaho Administrative Code.

**Paid providers
 are 3.6 x more
 likely than
 volunteers to be
 licensed to
 provide
 intermediate or
 advanced life
 support.**

For example, an adult facing cardiac arrest will receive a different level of care depending on the provider's license level. EMRs can administer oxygen, but only EMTs and higher licenses can administer aspirin. An EMT can also administer prescription-level medication to widen the blood vessels if it has been prescribed by the patient's doctor. AEMTs can administer medication to widen the blood vessels even if there is not a record of prior prescription.

Another example of varied patient care would be in response to a child in severe pain from a car accident or another incident. EMRs can assess the child using a pain scale, but only EMTs and higher licensures can administer ibuprofen or acetaminophen. AEMTs can also administer nitrous oxide. Only paramedics, the highest level of licensure, can administer prescription-level medications like morphine for pain and ketamine for sedation.

Some parts of the state can provide more advanced life support in an emergency because they have a mix of licensed EMS providers that allows agencies to send appropriately trained professionals for each situation. Several stakeholders reported challenges with maintaining high standards of care in rural Idaho. These stakeholders explained that it is difficult to ask volunteers to dedicate more time towards training when recruiting and retaining volunteers is already difficult. Challenges are compounded by the fact that volunteers in rural areas have limited training resources (see appendix D).

“ That's where you have to be careful. If you mandate too much training, there won't be volunteers anymore. – EMS agency official in Idaho County

We found that volunteers were licensed at a lower level than paid staff. Paid providers are 3.6 times more likely to be licensed to provide intermediate or advanced life support, according to our analysis of data from the bureau. EMS providers in rural counties are about half as likely to be licensed for intermediate or advanced life support than providers in urban counties, according to our analysis of data from the bureau and the US Census. Since rural areas rely more on volunteers, rural agencies are likely to have fewer EMS providers who are trained to provide intermediate or advanced life support (see exhibit 12).

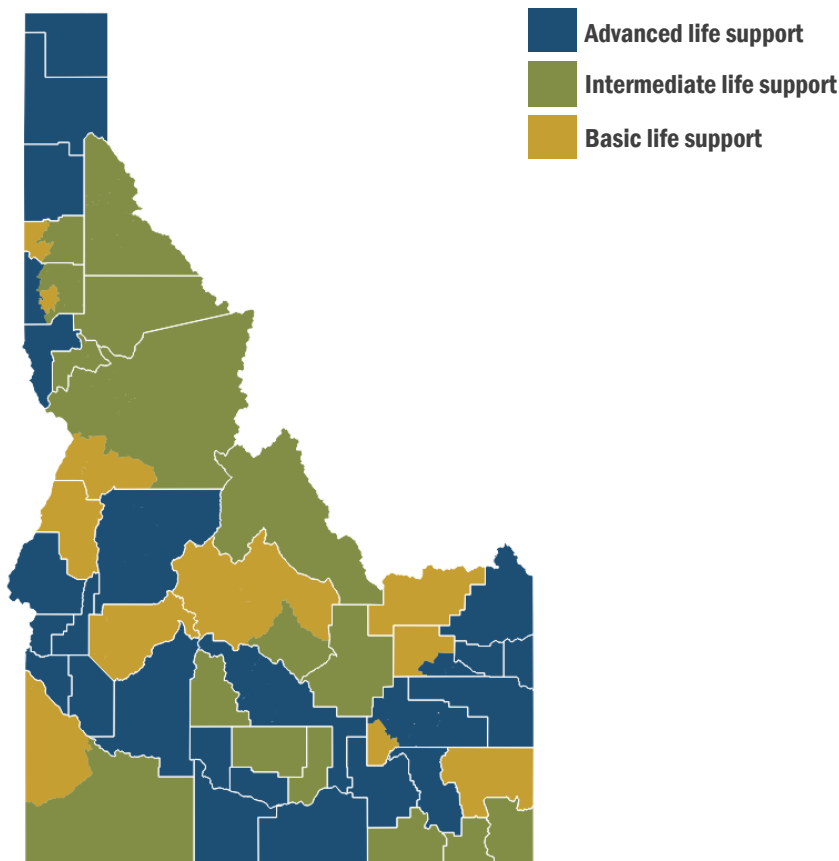
“ EMS is done so differently throughout the state that making any generalization about standards of care is close to impossible. – EMS agency official in Kootenai County

Compared with urban areas, hospitals are further away for people living in rural areas. Limited cell phone and radio coverage also make it difficult to send information to physicians for telehealth support. Some agency officials pointed out that these factors may make advanced training even more important for providing effective care in rural areas.

Exhibit 12

Compared to urban Idahoans, rural Idahoans are less likely to have access to higher levels of care in an emergency.

Primary transport agency licensure level by service area in 2021.



Notes: The bureau has allowed providers to maintain AEMT licensure even though standards have risen for newly licensed providers. As a result, EMS medical experts reported that some agencies are effectively providing basic life support though they may be categorized by the bureau as providing intermediate life support.

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

EMS providers in rural counties are about half as likely to be licensed for intermediate or advanced life support than providers in urban counties.

The bureau does not actively monitor whether agencies are meeting the 24-hour response requirement.

Limited ability to pursue grants for repair and replacement of vehicles and equipment

Some agencies that rely on volunteer administrators also struggle with their capacity to pursue grants available through the bureau, which in turn makes it harder for them to purchase vehicles and equipment that could improve patient outcomes. Our interviews revealed that agencies housed in organizations with some support staff, such as counties and hospitals, did not have issues with providing the information needed for grant applications. However, some all-volunteer rural agencies struggled to maintain staff resources to handle grant applications.

Longer response times

In our 2010 evaluation, we found that Idaho's EMS funding model and reliance on volunteers may not allow all agencies to have the resources needed to meet clinically meaningful response times for the patient.

“ We literally have listened to people screaming for help or had to listen to someone die on the radio because of a lack of response in a timely manner. – EMS official in Lewis County

An agency's response time to an emergency can affect patient survival. The chance of surviving cardiac arrest decreases by more than 5 percent for every minute that passes without CPR, defibrillation, and advanced cardiac life support.¹⁰ While other factors affect patient outcomes, national EMS officials commonly recommend a response time of less than 8 minutes. When agencies cannot recruit and retain staff, response times increase because agencies must service larger areas with fewer active stations and neighboring agencies must step in to help.

Agencies are not required to respond to emergencies in a certain amount of time to maintain their license. However, Idaho Code does require them to respond to emergencies 24 hours a day in the agency's declared service area. The bureau does not actively monitor whether agencies are meeting the 24-hour response requirement.

10. Mary P. Larsen et al., *Predicting survival from out-of-hospital cardiac arrest: a graphic model*, 22 ANNALS OF EMERGENCY MEDICINE 1652, 58 (1993), [https://www.annemergmed.com/article/S0196-0644\(05\)81302-2/pdf](https://www.annemergmed.com/article/S0196-0644(05)81302-2/pdf). (While much research has been done since, this is still the most cited report).

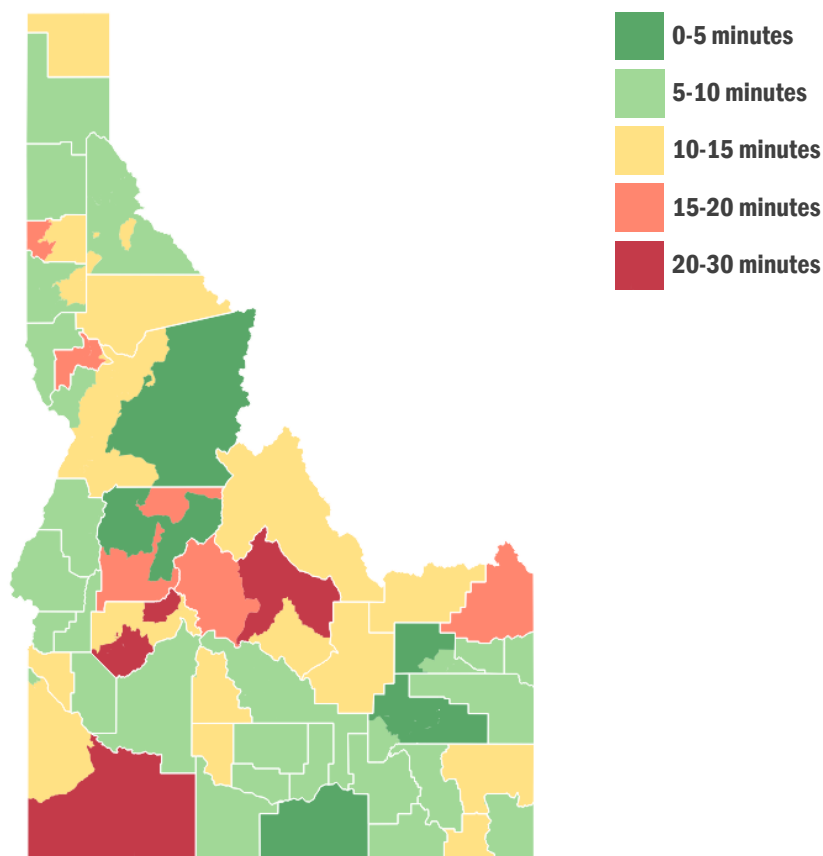
The best response time data the bureau has is reported directly by agencies on their annual licensure renewal applications. However, this data faces several limitations. Agencies may not track their response times well enough to accurately estimate an average annual response time. Collecting this self-reported information at licensure renewal may accidentally encourage agencies to underestimate their response times out of concern about potentially losing their license. For more information on performance data limitations and potential solutions, see chapter 5.

Exhibit 13 shows wide variation in reported average response time. Average response times ranged from less than 5 minutes to 20-30 minutes. About half of agencies reported an average response time of 5-10 minutes.

Exhibit 13

The average speed of emergency response varies greatly depending on where you live in Idaho.

Primary transport agency self-reported average response time by service area in 2020.



Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

For more information on performance data limitations and potential solutions, see chapter 5.

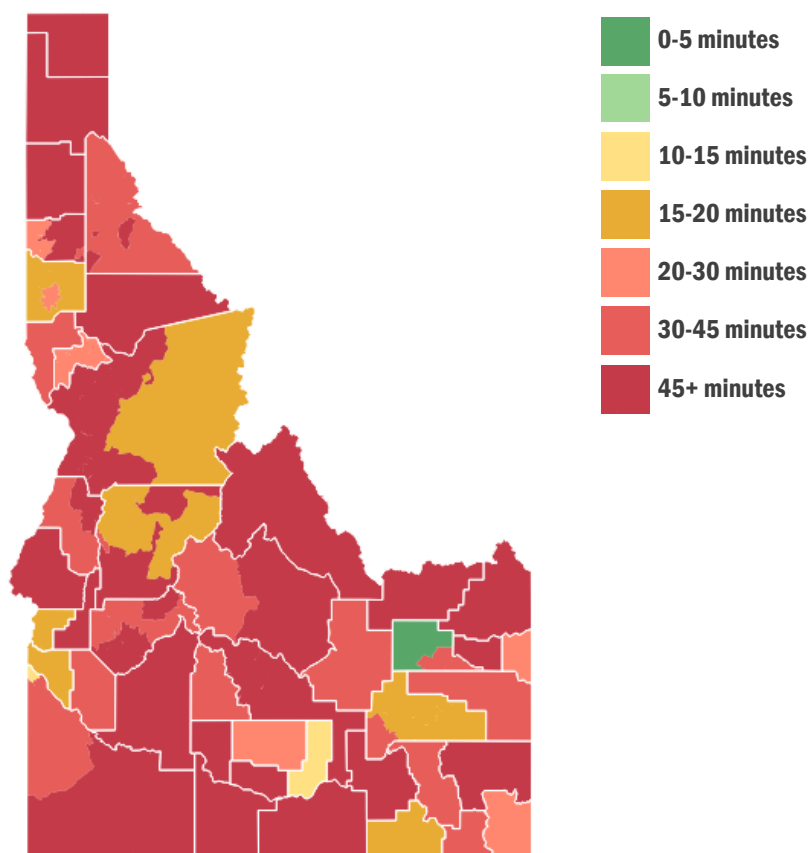
EMS officials reported that insufficient staffing is a driver of delayed response times.

Agencies also estimate their longest response time when renewing their license. Exhibit 14 shows that self-reported longest response times are very high in most parts of the state. Bureau staff agreed when we raised concerns that outliers in the data likely reflect inaccurate agency-reported estimates.

Exhibit 14

More than 4 in 10 agencies reported that their longest response times took more than 45 minutes.

Primary transport agency self-reported longest response time by service area in 2020.



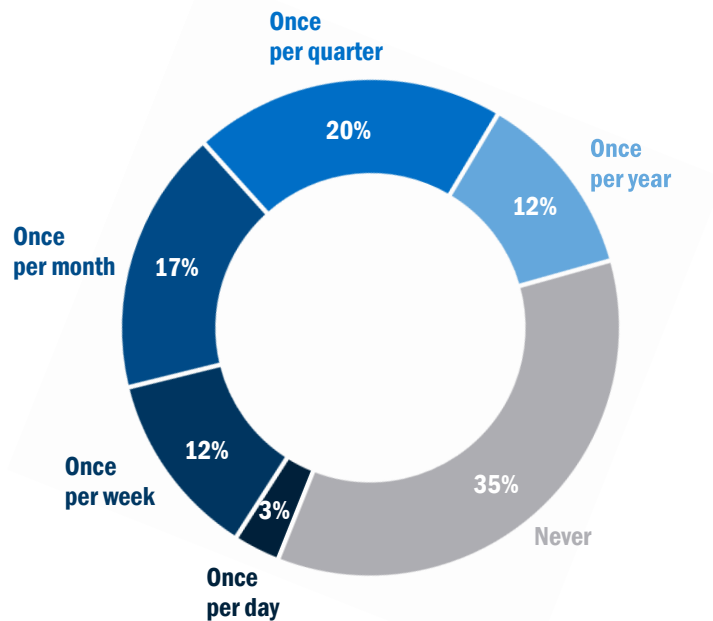
Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare.

EMS officials reported that insufficient staffing is a driver of delayed response times (see exhibit 15). Nearly two-thirds of agency directors reported that lack of staff availability caused them to be delayed by more than 15 minutes or unable to respond to a call in the past year. Although 12 percent of agency directors reported that this only occurred once annually, most reported more frequent response challenges due to insufficient staffing.

Exhibit 15

Nearly two-thirds of directors reported delayed response times due to staffing.

EMS agency directors reported frequency that lack of staff availability caused their agency to be delayed by more than 15 minutes or unable to respond to a call in the past year.



Source: Office of Performance Evaluations' survey of EMS agency directors.

The actual number of times that staffing affected response times could be different. The bureau does not track the effect of staffing on response times and only 49 percent of agency directors reported that their agency actively tracks this information.



When you talk about maturity of EMS systems, many agencies here never get past staffing the ambulance. So they can't ever get to working on performance. – Official with the EMS Physician Commission

1 in 3 agency directors reported that lack of staff availability affected response times at least monthly.

88% of agency directors reported that recruitment and retention of EMS volunteers in Idaho will only get harder in the future.

EMS officials reported that they believe recruiting and retaining staff will get harder.

Agency officials we interviewed reported a negative outlook on volunteer recruitment and retention in rural Idaho. No agency directors responding to our survey reported that they believe recruiting and retaining volunteers will get easier in the future and less than 12 percent reported that conditions will stay the same. More than 88 percent of agency directors reported that they believe it will get harder to recruit and retain volunteers in the future.

In our interviews, officials raised concerns about increasing demand for EMS because of aging rural residents and more people from out of town passing through or staying for recreation. At the same time, younger residents continue to move away from rural areas, decreasing the pool of potential volunteers and property tax base of people in their prime working years. Agency officials and other stakeholders reported being fearful that quality of care would decline until agencies close altogether in rural areas.

“ We don’t have volunteer garbage men but insist on EMS being provided by volunteers with minimal funding. – Official with the EMS Physician Commission

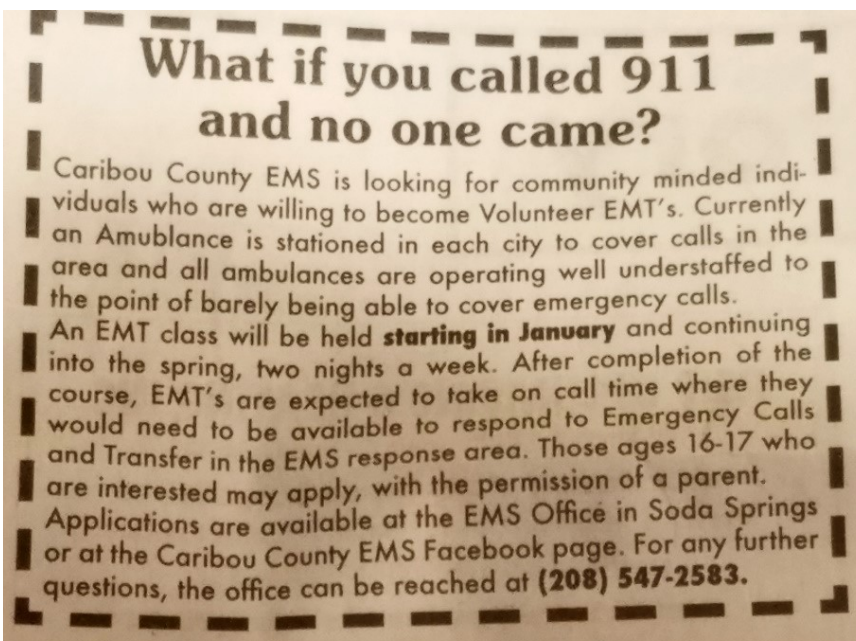
“ You rely on your strongest people to help you out and then they get burned out. – EMS agency official in Gem County

“ You’re just going to see folks locking the doors and turning off the lights. – EMS agency official in Caribou County

Recommendations and policy considerations

5

More than 76 percent of EMS agencies that rely on volunteers reported that they are actively recruiting. Our interviews found that agencies are taking creative approaches to recruit and retain personnel. Agencies recruit at farmers' markets and other community events. They post flyers and advertise through social media and local news outlets. Some collaborate with education institutions like high schools, colleges, and private EMS training programs in their area. Yet agencies reported facing barriers that feel insurmountable. Idaho has several options to pursue if the state wishes to improve recruitment and retention of EMS volunteers.



Source: Caribou County EMS.

The bureau did not have accurate and complete patient care reports for 74% of emergency response calls by primary transport agencies in 2020.

We recommend that the bureau improve monitoring and technical assistance for agencies to meet the response requirement.

The state has made little progress on our 2010 recommendations related to governance. We found that ongoing data limitations restrict the state's ability to increase and target support for staffing issues in an evidence-based manner. The bureau is tasked with overseeing licensure of agencies, but it is currently unable to tell whether agencies are meeting their requirement to respond to emergencies 24 hours a day in their service area.

Limited data has restricted the bureau's ability to serve as a knowledge base and information clearing house. That means the bureau is not as strong of a resource as it could be in helping agencies address volunteer recruitment and other challenges or helping to communicate agencies' needs to policymakers. The bureau should improve performance data tracking and remove barriers to data reporting.

Provide agencies with technical assistance to improve performance data

According to the EMS Data Collection and Submission Requirements, agencies must provide the bureau with accurate and complete patient care reports for each EMS response.¹¹ The reports include information on response time, patient conditions, and services administered. Local medical directors rely on patient care reports to provide quality control of services rendered.

The bureau did not have accurate and complete patient care report data on 74 percent of emergency response calls by primary transport agencies in 2020. The bureau received 38,000 patient care reports although agencies reported having more than 146,000 calls. The bureau did not have any patient care reports for 42 percent of the calls.

11. IDAHO ADMIN. CODE r. 16.01.06.100, (2021), <https://adminrules.idaho.gov/rules/current/16/160106.pdf>.

Our interviews revealed several causes of low compliance:

insufficient resources

staff turnover

unclear expectations

incompatible data systems

ambiguous consequences for noncompliance

Both agencies and the bureau struggle with resource scarcity. Agencies experience staff turnover and the bureau does not have funding to provide ongoing training to agency staff on how to submit patient care reports or why reporting is important.

Agencies seem to be unclear about the details of reporting requirements. The bureau reported that staff at some agencies, especially small rural ones, struggle to understand the need to submit performance data. Some agencies may not be reporting all the calls they respond to because they are unsure whether cases involving response and evaluation without further treatment should be included. The bureau also reported that some of the emergency calls reported at EMS licensure renewal may not require patient care reports.

Agencies face technical issues because their data systems are incompatible with the system used by the bureau. The bureau recently changed the type of software used to collect data. Some agencies have had trouble aligning their front-end systems with the bureau's new software. Agencies may be submitting patient care reports that are rejected by the bureau's software because not all required data points were entered, according to bureau staff. Some agencies may not know that they are out of compliance.

In 2017, the bureau stopped keeping patient care reports current with standards set by the National EMS Information System (NEMSIS), a collaboration between the National Highway Traffic Safety Administration and the University of Utah. Idaho is one of only three states that does not have data available through NEMSIS.

There are consequences for not reporting patient care data. Researchers across the country use NEMSIS to analyze patient care reports and provide recommendations to improve EMS. The bureau could be a resource to agencies for this kind of

Idaho is one of only three states that does not have performance data available through the National EMS Information System.

Agencies must respond to emergencies 24 hours a day unless they have an active waiver.

information. However, without the data, the bureau is not as useful as it could be. Our evaluation also could have benefited from accurate patient care reports and continued collaboration with NEMSIS. For example, patient care reports would have provided more accurate response times than the self-reported data from annual licensure renewal we referenced in chapter 4.

Track agencies' need to waive the response requirement

Unlike EMS agencies in other states, agencies in Idaho do not have to respond to emergencies in a certain amount of time to keep their license. However, agencies must respond to emergencies 24 hours a day. Based on Idaho Code dating back to 1976, EMS Agency Licensing Requirements state that “each EMS agency must respond to calls on a twenty-four (24)-hour-a-day basis within the agency’s declared geographic coverage area.”¹² The bureau does not regularly monitor whether agencies are able to meet the response requirement.

If agencies cannot comply with response requirement, Idaho Code allows them to apply for a temporary waiver. To be eligible for a waiver, Administrative Code requires that agencies provide

- a description of their operational limitations to provide 24-hour response;
- a description of the initiatives underway or planned to provide 24-hour response;
- a staffing and deployment plan identifying the agency’s response capabilities and back-up plans for services to the community when the agency is unavailable; and
- a description of collaboration with other EMS agencies providing services within the petitioner's geographic response area.

The bureau reported that nine agencies had a formal waiver in 2021. The bureau does not track whether the number of waivers has changed over time or whether the average length of time that waivers are in place has changed.

12.IDAHO ADMIN. CODE r. 16.01.03.520, (2021), <https://adminrules.idaho.gov/rules/current/16/160103.pdf>.

Since the bureau does not monitor whether agencies are meeting the response requirement, some agencies may not have a formal waiver of their responsibilities even though they are unable to respond 24 hours a day. Without a waiver, agencies do not need to provide the bureau with service improvement plans or any agreements for temporary coverage by other agencies.

Bureau officials reported that the bureau does not monitor whether agencies are able to meet the response requirement because responding 24 hours a day does not have a clear definition. Although agencies must submit patient care reports with information on response times, the bureau expressed concerns that too much pressure on agencies to submit patient care reports would drive away volunteers and full enforcement of the requirement would close agencies, leaving areas without EMS. Instead, the bureau relies on what has been referred to as the honor system, requesting staff rosters. Intermittently updated rosters do not provide sufficient information about staff turnover or reliability. Volunteers often have other obligations when they are on call, which can make it difficult for them to respond to emergencies.

We found support for the bureau's concern over the ability of agencies to meet the requirement to submit patient care reports. To improve compliance, agencies would need assistance from the bureau to identify and address software challenges. Volunteer turnover may require ongoing training as well.

The bureau should address data challenges so that the patient care reports already required of agencies can be used by the bureau itself, researchers, and policymakers to improve EMS. The bureau tries to help agencies when staffing issues are brought to its attention. However, reliable patient care reports would allow the bureau to proactively reach out to struggling agencies to help ensure temporary coverage by another agency, create a service improvement plan, and provide other technical assistance. Data from patient care reports may eventually be used to develop a staffing formula to target support. The bureau should also be able to tell legislators whether any potential investments to increase staff recruitment and retention are improving EMS performance for Idahoans.

Some agencies may not have a waiver of their responsibilities even though they are unable to respond to emergencies 24 hours a day.

Without a waiver, agencies are not required to provide plans for service improvement or temporary coverage by other agencies.

The bureau and agencies reported that funding is a significant limiting factor.

The Legislature could support agency recruitment and retention efforts by providing financial compensation, benefits, and training.

Under the status quo, the bureau is limited in the amount of technical assistance and oversight it can provide, many agencies are struggling to staff a 24-hour, 7-day-a-week operation, and Idaho has inconsistent EMS. The bureau and agencies reported that funding is a significant limiting factor they face to address these challenges.

In our 2010 evaluation of EMS, we recommended that the state fund agencies based on the cost of readiness. The state has not adopted this recommendation. However, the state could take a different approach by providing targeted support to address recruitment and retention challenges. We identified three ways that the Legislature could provide assistance to the agencies:

- assist with financial compensation for volunteers
- expand employee benefits to include volunteers
- support EMS training

We identified these strategies through a review of the following sources:

- reports from other states, federal agencies, and EMS advocacy groups
- academic literature
- survey of agency directors
- review of documentation from statewide townhall meetings in 2012 and 2018

More information about our review process can be found in appendix C. During our review of national EMS data, we found that there was not enough information to rank recruitment and retention strategies by effectiveness. In the following sections we are presenting information about the potential impact these strategies would have according to our survey results and interviews with agency officials.

Financially compensating EMS volunteers

Agency directors reported in our survey that fully compensating volunteers as employees would be most effective at improving recruitment and retention. Other financial incentives, namely stipends and tax incentives, were also listed in the top six most effective policy solutions.

Our interviews also revealed strong support for making EMS an essential service in statute and funding sufficient career staff to resolve issues related to volunteer recruitment and retention. Agency officials we interviewed reported that standards of care vary across the state because there is not enough local funding in rural areas to support fully paid staff.

“ What needs to happen is to focus less on volunteerism because it’s clearly not working. Instead focus on funding career staff across the state. – EMS agency official in Canyon County

“ I think relying solely on volunteers is not sustainable. We are going to have to explore other models. – EMS agency official in Bannock County

“ The answer is not trying to find more 75-year-olds to hold a stretcher. The answer is not trying to find more volunteers. We could spin our tires for a long time and never get ahead. The answer is funding agencies so that they can pay people. – EMS agency official in Kootenai County

Having a paid EMS position could allow providers to fully commit to EMS without needing to prioritize another job for their financial needs. The state could fund agencies to ensure sufficient staff in rural Idaho. For example, the state could use the bureau to distribute funding through a staffing formula based on local need.

Our literature review did not reveal agreed upon best practices for sufficiently funding or staffing EMS because governance varies in each state and needs vary by community. If the state paid EMS volunteers the prevailing Idaho wage for their profession, the annual cost is estimated to be \$140.2 million.

Agency directors reported that fully compensating volunteers would be most effective at improving recruitment and retention.

Washington and Wyoming provide retirement benefits to volunteers who work for any type of EMS agency.

This estimate includes employee benefits and employer taxes, and is based on data from the bureau, the Department of Labor, and the Division of Financial Management. The Department of Labor does not provide wages by licensure level. Since Idaho's paid EMS providers are more likely to have a higher licensure level than volunteers, the actual cost of paying volunteers may be lower because they would likely be paid less than the current prevailing wage.

Employee benefits

Idaho has self-employed and contract employees, who may have more flexible schedules that allow them to volunteer during traditional work hours. To attract more of these workers, the Legislature could extend state employee benefits to EMS volunteers since many may not have access to benefits through their employer. Agency directors ranked retirement savings and healthcare benefits in the top six most effective policies to recruit and retain EMS volunteers.

Retirement savings

State employees have access to the Public Employee Retirement System of Idaho (PERSI). Like state employees, volunteers could be made eligible for retirement benefits after a fixed amount of public service. States including Colorado, Montana, Nevada, New Mexico, Washington, and Wyoming have programs that provide retirement benefits to volunteers who work for any EMS agency or an EMS agency that responds to fires.

PERSI has a pension with defined benefits after retirement and a 401(k) plan with defined contributions. Employees have different PERSI options depending on which government entity they work for and the type of work they do. Defined benefit plans offer more stability for employees but more risk for the employer since payments are guaranteed through the end of life. PERSI officials reported that new defined benefit plans often take 10 years or more of observation to refine cost estimates.

Defined contribution plans offer less risk for employers but less stability for employees. Governments taking part in PERSI can match 401(k) contributions just like other employers can. PERSI employer matches range from zero to 6.2 percent of employee wages.

Idaho relies on actuarial firms to estimate costs associated with retirement benefits. See appendix F for actuarial estimates of

three hypothetical retirement plans for EMS volunteers. Legislators have many more options in designing retirement plans. Should the Legislature wish to pursue retirement benefits for volunteers, PERSI officials reported that more detailed actuarial of proposed legislation would be needed, in addition to tax and legal analysis.

Health insurance

An informal collaboration of EMS agencies known as the Latah County EMS Council surveyed 92 volunteers in the area and found that only 61 percent had health insurance through their employer. Health insurance benefits may be particularly attractive for rural Idahoans to volunteer as they are more likely to be uninsured than urban Idahoans.

If health insurance coverage among volunteers is like coverage among all Idahoans, about 28 percent are uninsured or purchase their health insurance directly, according to our analysis of US Census Bureau data. Providing health insurance to 28 percent of EMS volunteers would cost the state \$6.4 million annually based on medical and dental plan costs from the Office of Group Insurance. The state's health insurance plan also includes access to confidential, short-term counseling services through the Employee Assistance Program.

This estimate assumes that volunteers would pay for their share of health insurance costs as state employees currently do. Enrollment may be higher if the state does not limit eligibility to people without access to other health insurance options. Health insurance access could also be limited to EMS volunteers in rural areas with smaller property tax bases. In 2021, the Utah Legislature proposed a bill to provide health insurance to EMS volunteers in counties with fewer than 175,000 residents.

EMS training

EMS requires a diverse set of physical and cognitive skills to be able to provide lifesaving care for the public at their most vulnerable moments. To obtain and maintain EMS licensure, providers must go through initial training, testing, background checks, and continuing education. The state does not fund most requirements for licensure (see appendix D). EMS directors who responded to our survey ranked funding EMS training as the fourth most effective way to improve recruitment and retention of volunteers.

The bureau could improve the reach of its current test voucher program for volunteers, as discussed in appendix D. While bureau officials recognized the need to help retain volunteers in rural areas with few training resources, the bureau does not have funding to support new training programs. The Legislature could fund EMS initial training, continuing education, and background checks for volunteers. Our interviews also indicated that funding these EMS licensure requirements would improve recruitment and retention of volunteers.

Initial training

Funding background checks and training requirements for newly licensed volunteers in 2020 would have cost the state \$455,000 based on the cost of standard background checks performed by the department and the low end of average training costs approved by the bureau.

Continuing education

The bureau contracts with inspectors to visit each agency at least once annually to ensure equipment and supply requirements are met. The bureau could use a similar process to provide in-person training to help volunteers meet the continuing education requirements for licensure. The bureau estimated that providing in-person training for agencies would cost \$83,500 annually.



Source: Moscow Volunteer Fire Department.

Request for evaluation



Idaho Senate & House of Representatives

March 5, 2021

Joint Legislative Oversight Committee

Dear Co-Chairs Senator Harris and Representative Rubel,

Idaho remains one of the fastest growing states in the nation, and not all of that growth is in urban areas. Rural communities are seeing increasing populations, increased tourism, increased traffic and increased pressure on volunteer first responders. New community members are often retirees, more in need of services than potential providers of volunteer services. Young community members are busy with full time jobs and raising families.

Background

At the heart of rural communities across Idaho are the local volunteer Fire and Ambulance Departments. They are held to the same training and response standards of their paid counterparts in urban areas, providing safety to our rural citizens on their property, in their homes, and to all travelers on the roads.

Idaho's reliance on volunteer EMS and Fire responders is in danger of collapsing under the weight of increased community need, challenges of recruiting and retaining volunteers, and scrambling every year to secure their own funding for their programs through grants, donations and events.

Over the past decade, numerous reviews, reports and studies have taken place regarding various aspects of emergency medical services (EMS) in Idaho. They focused on the governance of agencies, duplication of services, gaps in services, and challenges in recruitment and retention of volunteer EMS personnel. These include the following:

- 2010 Office of Performance Evaluation (OPE) award-winning report on the governance of EMS services in Idaho.
- 2012 Senate Concurrent Resolution 131 requesting the Department of Health and Welfare to conduct outreach town hall meetings throughout Idaho to

explore solutions to the challenges hindering the recruitment and retention of volunteer emergency medical services personnel.

- 2013 OPE follow up report on the governance of EMS services in Idaho.
- 2018 Senate Concurrent Resolution 135 requestion the Department of Health and Welfare for follow-up town hall meetings.

These reports have resulted in numerous changes in EMS education and training and support for continuing education. Unfortunately, the work has not resulted in significant policy changes addressing the most important issues: recruitment and retention of volunteer responders.

In rural communities, the volunteer fire fighters go hand-in-hand with the EMS team. The "Idaho Volunteer Fire and Emergency Services Association (IVFESA)" website states that they represent over 8,000 volunteer firefighters and emergency medical technicians across Idaho, which is over 75% volunteer." They provide recruitment and retention help, local training and a firefighter "training academy," and represent Idaho on the National Volunteer Firefighter Council (NVFC). They are funded through \$35 individual membership dues, direct donations or events.

There appears to be coordination between the local volunteer fire departments and the fire response by the Idaho Department of Lands, but the issues addressed in the initial OPE study for EMS including governance of agencies, duplication or gaps in services, coordination of efforts, and volunteer recruitment and retention have not be conducted.

In addition to grants and donations, EMS and fire response can be covered for local communities by property taxes collected by the county and distributed to the authorized ambulance and fire taxing districts.

Request

Idaho needs to determine ways to recruit and retain volunteer firefighters and EMT's. We would like this OPE study to focus on:

- Determining the scope of the problem (map location of departments and survey numbers of current and needed first responder volunteers),
- Review EMS administrative improvements and findings since the 2010 and 2013 OPE Evaluations and the 2012 and 2018 Town Hall sessions,
- Review of organizational structure and partnerships between Idaho's volunteer fire departments and other local and state agencies (Professional first responder units, Training Academies, Idaho Department of Lands, others),
- Identify best practices among rural states,
- Survey first responders to determine issues and outlook,

- Study and propose possible solutions to recruiting and retaining volunteers, including health benefits, retirement savings opportunities, and other options.

Thanks for your consideration.

Rep. Caroline Troy

Rep. Brandon Mitchell

Rep. Matt Bundy

Sen. Carl Culha

Sen. Del Hall

Sen. Mill -

Senator Byers



Evaluation scope

1. Discuss the governance of EMS in Idaho and recent attempts to improve coordination.
2. Provide information regarding Idaho's reliance on EMS volunteers.
3. Assess the perceived shortage of volunteers and need to improve their recruitment and retention.
4. Identify best practices for legislators in rural states to improve recruitment and retention of EMS volunteers.

Methodology



Our evaluation involved literature reviews, interviews, a survey, and statistical analysis. Mixed methods allowed us to address some data limitations and shed light on Idaho's EMS system by drawing on the strengths of both qualitative and quantitative analysis.

Literature review

We reviewed reports resulting from Senate Concurrent Resolutions 131 and 135 asking the Department of Health and Welfare to conduct town hall meetings regarding volunteer EMS recruitment and retention. We also examined budgets, statute, rules, and performance reviews for the department. Our evaluation relied in part on research about EMS funding and staffing. We reviewed medical journals and studies funded by states, the federal government, and nonprofit organizations. Our search focused on the following areas:

- EMS funding models
 - barriers to sufficient funding and approaches to reliably funding EMS
- EMS staffing benchmarks
 - best practices in recruitment and retention of EMS staff and evidence of improving performance
- effect of EMS response times, licensure level, and other performance metrics on patient outcomes

Policy implementation is complex, and EMS varies across the country. While government and stakeholder groups had various suggestions, there was not consensus in academic research about performance outcomes for various funding models, staffing benchmarks, and practices for recruitment and retention. These topics were a focus of our survey and interviews.

Survey

Local agencies are at the heart of EMS in Idaho. We surveyed agency directors to learn about their perceptions regarding funding, staffing, and other issues. Some questions were open-ended while others used Likert response options to indicate the intensity of agreement or disagreement. Each multiple-choice question had an open-ended comment section for respondents to provide additional context. Many agency directors used this opportunity to share their opinion or provide more detail in their response.

We asked the bureau to help review and encourage participation in the survey since it is a key part of Idaho’s EMS response. In the last week of June 2021, the bureau emailed our survey to 182 agency directors representing all agencies licensed in Idaho. The bureau also encouraged agencies to check their email through a social media post. The bureau also sent two reminder emails over the following two weeks.

Agencies that rely on volunteers were more difficult to reach. Since our evaluation focused on volunteer recruitment and retention, participation from volunteer agencies was especially important. Our staff called all the agencies that did not respond by the first week of July. We recorded some responses by phone from agencies with limited internet access. Agencies we reached by phone reported being interested in the evaluation but busy. Many noted increased call volumes due to the pandemic and fire season. The following week, our staff called agencies we were unable to reach by phone the first time. Finally, the bureau called a list of agencies that had not yet responded in the last week of July.

We closed our survey in August with 98 responses, representing 49 percent of agencies with fully paid staff and 54 percent of agencies that have volunteers.

Responding agencies came from the following counties:

| | | |
|-----------|---------|------------|
| Ada | Benewah | Bonneville |
| Adams | Bingham | Boundary |
| Asotin | Blaine | Butte |
| Bannock | Boise | Canyon |
| Bear Lake | Bonner | Caribou |

| | | |
|------------|-----------|------------|
| Cassia | Jerome | Owyhee |
| Clark | Kootenai | Payette |
| Clearwater | Latah | Power |
| Custer | Lemhi | Ravalli |
| Elmore | Lewis | Shoshone |
| Franklin | Madison | Teton |
| Gooding | Minidoka | Twin Falls |
| Idaho | Nez Perce | Valley |
| Jefferson | Oneida | Washington |

Interviews

Stakeholder interviews were our primary method of understanding the status of collaboration and context on local staffing challenges. Interviews also provided additional detail concerning various funding models. Stakeholder interviews were sometimes difficult to schedule or were interrupted due to emergency calls. We conducted more than 40 interviews. Most interviews were an hour long. The questions were open ended and varied depending on stakeholder expertise. We interviewed volunteer and paid personnel in various roles with the following diverse types of EMS agencies in Idaho:

- agencies working in different organizational structures, including
 - coordinated EMS systems,
 - cities,
 - counties,
 - fire departments,
 - hospitals,
 - non-profits, and
 - tribal nations;

agencies providing different types of services, including
transport services and
non-transport services;

agencies operating under different scopes of practice,
including

basic life support,
intermediate life support, and
advanced life support.

We also interviewed members of stakeholder groups and officials governing aspects of EMS provision in Idaho, including

Idaho Association of Counties,
Boise State University School of Public Service,
Department of Health and Welfare,
Division of Medicaid,
Division of Public Health
Bureau of EMS and Preparedness,
EMS Advisory Committee,
EMS Physician Commission,
Idaho Fire Chiefs Association,
Idaho Hospital Association,
Time Sensitive Emergency System Council, and
Idaho Volunteer Fire and Emergency Services
Association.

Budget analysis

Unless otherwise specified, data throughout this evaluation is reported by calendar year, which happens to be the same as the tax year.

In our 2020 report, *County Revenues*, we found limitations in the availability, uniformity, and specificity of county budget data. We found similar data limitations for ambulance service and fire protection districts in this evaluation. In 2021, House Bill 73 made several changes to encourage more transparency in local budgets. However, our analysis focused on 2019 because the COVID-19 pandemic has temporarily affected revenue needs and resources since then. Although tax districts were required to submit budgets to the Legislature, they did not use a uniform chart of accounts and they reported little information on revenue from sources other than property taxes. Our analysis of 2019 property tax revenue primarily relied on two types of reports from the Tax Commission:

the L2 Form, which is submitted by counties during the budget and levy certification process and includes levies and property tax budgets for each tax district, and

the Report 04 fund detail within county, which lists taxable market values, levy rates by fund, and property tax budgets by fund for each tax district.

As discussed in chapter 3, property taxes have statutory restrictions intended to suppress tax growth. Districts may increase their total budget by up to 3 percent higher than the largest budget they had over the prior 3 years. This cap applies to most property tax levies, including when a district is not yet at their maximum levy rate. Budget growth restrictions added in 2021 through House Bill 389 did not apply to our analysis of 2019 tax revenue. In 2019, the budget cap accounted for the following adjustments after the initial 3 percent calculation.

New construction is typically the value of new buildings, improvements to existing commercial buildings, and land that has changed use. The net value of new construction is multiplied by the previous year's nonexempt levy rate, the product of which is then available for tax districts to include in their budget.

Annexation occurs when an area joins a tax district to gain access to services. The net value of newly annexed property is multiplied by the previous year's nonexempt levy rate, the product of which is then available for tax districts to include in their budget.

Forgone revenue refers to the share of maximum allowable increases that a tax district did not request in earlier budgets. Previously forgone budget increases may be added to tax district budgets following a public hearing.

Voter-approved bonds require a vote with two-thirds majority to pass and are exempt from the budget cap. Twelve fire protection districts and no ambulance service districts had voter-approved bonds in 2019.

Voter-approved override levies may be permanent or temporary with a limit of up to two years. Permanent override levies require a two-thirds majority vote to pass. Temporary override levies require a simple majority to pass. Override levies are exempt from the budget cap if the budget remains under the levy limit. One fire protection district and no ambulance service districts had voter-approved override levies in 2019.

We found that 50 percent of ambulance service districts and 57 percent of fire protection districts were at their maximum taxing capacity of the budget cap after accounting for new construction and annexation. Nearly 86 percent of ambulance service districts and 90 percent of fire protection districts were at 95 percent of their maximum taxing capacity.

Some tax districts had foregone revenue, but foregone amounts were generally too small to be used for operating costs related to personnel. Nearly 43 percent of ambulance service districts and 59 percent of fire protection districts had less than \$1,000 in foregone available after their 2019 budgets. To increase their taxing capacity, districts would need to go to the voters for approval.

Even less information is available concerning how this property tax revenue goes from tax districts to service providers. Some tax districts provide EMS directly and others distribute tax district revenue to separate agencies. Tax district budgets submitted to the Legislative Services Office are not required to provide this level of detail.

Still less information is available about agency budgets. EMS agencies are not required to submit their budgets to the Legislative Services Office. They are only required to submit summary information about their budgets to the bureau on their initial licensure application and if they apply for the vehicles and equipment grant. As discussed in chapter 3, some agencies do not have software capabilities to provide detailed budgets even when prompted for this information. We therefore relied on our survey of agency directors, interviews, and national reports to provide additional context on agency budgets.

Training



Training is necessary to maintain standards of care for patients and to prevent provider burnout. At the same time, agency officials reported that training requirements are rigorous, time consuming, and costly, making them challenging for volunteers to meet.

Idaho and 45 other states use the National Registry of Emergency Medical Technicians as a basis for initial licensure. The registry certifies four levels of EMS professionals: emergency medical responder (EMR), emergency medical technician (EMT), advanced emergency medical technician (AEMT), and paramedics. Just like paid staff, volunteers must complete an EMS education program and pass both a cognitive and psychomotor exam to apply for an EMS license in Idaho.

Most agency officials did not question the validity or necessity of the licensure process, but several pointed out that it is relatively common for volunteers to fail their exams. In 2020, more than a third of Idahoans who took the EMT cognitive exam for the first time failed.

The bureau approves training programs in Idaho to prepare for the cognitive and psychomotor exams needed for licensure. Exhibit 16 displays estimated cost and time commitment for training, licensure, and continuing education for each level of EMS professional. Licensure standards have increased over time. Agencies reported that volunteers are hesitant to upgrade to new standards. Out of concerns about losing staff, the bureau developed optional training modules to allow providers licensed under old standards to slowly increase their training if they want to do so. Newly licensed staff must follow current standards.

Exhibit 16

EMS licenses require different time and financial commitments.

Estimated costs and time needed for various Idaho EMS license levels in 2021.

| License | Estimated training course hours | Estimated training course and psychomotor exam cost | Cognitive exam cost | Initial license cost | Continuing education | License renewal cost |
|--|---|--|---------------------|----------------------|------------------------|----------------------|
| Emergency Medical Responder (EMR) | 48-60 hours | Offered primarily through high schools and agencies at little or no cost | \$85 | \$0 | 24 hours every 3 years | \$0 |
| Emergency Medical Technician (EMT) | 150-190 hours | \$1,400-\$1,500 | \$98 | \$0 | 48 hours every 3 years | \$0 |
| Advanced Emergency Medical Technician (AEMT) | 150-250 hours plus time for EMT license | \$1,400-\$2,500 plus cost of EMT license | \$136 | \$35 | 54 hours every 2 years | \$25 |
| Paramedic | 2-year associate's degree plus time for EMT license | \$9,300-\$14,800 plus cost of EMT license | \$152 | \$35 | 72 hours every 2 years | \$25 |

Note: The bureau does not track the cost to students or agencies of training it approves for licensure.

Source: Office of Performance Evaluations' analysis of Idaho Administrative Code and data from National Registry of Emergency Medical Technicians, the Department of Health and Welfare, and a sample of EMS courses hosted by community colleges and private companies. Sample courses were approved by the bureau and listed on Idaho's Gateway for Emergency Medical Services in August 2021.

The state does not fund EMS volunteer training. The bureau has conducted instructor development conferences to increase the number of people who can lead EMS trainings across the state. Some agencies also reimburse volunteers for tuition, hire an outside instructor, or send staff to go through the process of becoming an approved instructor. But many agencies reported having limited resources, requiring them to prioritize hosting training over other investments, such as staff salaries, buying supplies, or updating equipment. Some agencies are unable to afford training, meaning volunteers are left trying to find free opportunities out-of-town or paying out-of-pocket for training required to receive and maintain EMS licensure.

The bureau has tried to offset costs by supplying some volunteers with books and vouchers to cover the cost of tests needed for licensure. While any new EMR, EMT, and AEMT volunteer is eligible for a test voucher, they must know about the program and apply for it. In 2020, just 12 percent of eligible newly licensed EMS volunteers had their national registration fee paid for by the bureau's voucher program.

The bureau has helped financially sponsor regional EMS conferences that could help providers meet some of the continuing education requirements to maintain licensure, but these sponsorships have not covered the cost of volunteer attendance. Attending conferences requires a financial and time commitment for volunteers who must travel, take time off work, and sometimes stay overnight in a hotel.

The bureau and Time Sensitive Emergency System Council have hosted online training opportunities from time to time. Unfortunately, online trainings have not been used by many rural providers, who are generally older and, according to our interviews, may prefer in-person learning. The bureau has also struggled to maintain and promote a learning management software to store free training opportunities for providers to access on their own time.

Moreover, some rural providers may never learn about remote training opportunities. While agency officials were helpful and generous with their time, we found that it can be difficult to get ahold of rural agencies that rely on volunteers (see appendix C). Rural agency officials emphasized that communication from the bureau to rural agencies needs to be strategic by developing long-term relationships with as much contact in person as possible. Online trainings sent through a newsletter do not fit this model, though they may be less expensive than in-person options.

Just 12%
of eligible EMS
volunteers had
their national
registration fee
paid for by the
bureau's voucher
program in 2020.

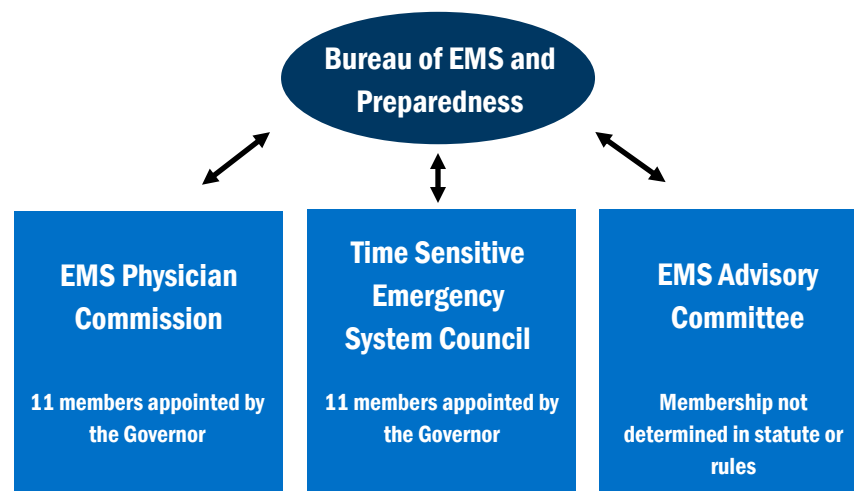


Representative bodies

The bureau coordinates with three representative bodies. Each of these bodies holds public meetings. Agency officials reported that it is harder for rural agencies to participate (see exhibit 17).

Exhibit 17

Three representative bodies help the bureau govern EMS.



Note: The Time Sensitive Emergency program also oversees the EMS for Children program, which has an advisory committee.

Source: Office of Performance Evaluations' analysis of Idaho Code, Administrative Code, and stakeholder interviews.

EMS Physician Commission

The EMS Physician Commission is an independent governing body that determines scopes of practice and medical supervision standards. Commissioners are appointed by the Governor.

The physician commission includes people from the following organizations or in the following roles:

the American Academy of Pediatrics

the American College of Surgeons Committee on Trauma

the American College of Emergency Physicians

the bureau

the Idaho Association of Counties

the Idaho Medical Association

the Idaho Fire Chiefs Association

the Idaho State Board of Medicine

the Idaho Hospital Association

two citizens

During our interviews, agency officials reported that the physician commission helps keep Idaho on track with national EMS standards while allowing agencies needed flexibility.

Time Sensitive Emergency System Council

The Time Sensitive Emergency (TSE) System Council implements a voluntary statewide program to respond to trauma, stroke, and heart attacks. The council oversees standards and regional committees to support TSE designation of hospitals and EMS agencies. Three full-time bureau positions coordinate with the council. Council members are appointed by the Governor.

The council includes people from the following organizations or in the following roles:

a trauma center

an air medical EMS agency

a stroke center

a TSE-designated hospital

a heart attack center

a TSE-designated critical access hospital

an urban EMS agency

an urban emergency department provider

a rural EMS agency

a rural emergency department provider

an Idaho citizen with an interest in furthering the quality of TSE care

Many agency directors spoke positively of the council during our interviews, reporting that it has improved service standards of care by facilitating communication between EMS agencies and hospitals.

EMS Advisory Committee

According to the bureau, EMS Advisory Committee members are appointed by the director of the Department of Health and Welfare. The bureau reported that the advisory committee's primary responsibilities are to advise the bureau on do-not-resuscitate directives, educational curricula and standards, personnel and agency licensing, grant applications, and the performance and sustainability of EMS.

The advisory committee includes people from the following organizations or in the following roles:

| | |
|---|--|
| the Idaho Department of Transportation | an emergency department physician |
| the Idaho Board of Nursing | a trauma surgeon |
| the Idaho Hospital Association | an EMT |
| North Public Health Districts | a volunteer EMS provider |
| South Public Health Districts | a career EMS provider |
| a non-transport agency | an air medical service provider |
| an administrator from a volunteer pre-hospital agency | an administrator from a private EMS agency |
| an EMS medical director | a fire chief |
| a pediatric emergency medicine physician | an EMS instructor |

The advisory committee has proposed initiatives to train agency administrators and create a provider recognition program for volunteers. The bureau reported that it has postponed these programs due to the Covid-19 pandemic.

Some agency directors described the advisory committee during our interviews as a tool for collaboration, while others reported that the committee is insufficient for regional problem solving. Most advisory committee members represent urban areas. Idaho Administrative Code no longer stipulates membership from particular organizations, regions, or roles.





Retirement estimates

Idaho Legislature, Office of Performance Evaluation

Volunteer EMS Retirement Benefit Study
Phase 1 Report

Robert Schmidt, FSA, EA, MAAA

Joel Stewart, FSA, EA, MAAA

SEPTEMBER 21, 2021



Methodology

- Looked at retirement benefit information for Volunteer EMS/Firefighters in nearby states
- The following states were analyzed:
 - CO, WY, MT, NM, UT, NV, and AZ
- Utah provides only death and disability for Volunteers
- Arizona did not have readily available public information
- Colorado does not have a state-wide system, but rather provides funding support to local municipalities who sponsor their own program



This work product was prepared solely for the Idaho Legislature, Office of Performance Evaluation, and may not be appropriate to use for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Any recipient of this work product who desires professional guidance should engage qualified professionals for advice appropriate to its own specific needs.

Summary of Findings

High-Level

- Specific programs reviewed:
 - Wyoming Retirement System Volunteer Firefighter, Emergency Medical Technicians and Search and Rescue Pension Plan
 - Montana Volunteer Firefighters' Compensation Act
 - Public Employees Retirement Association of New Mexico Volunteer Firefighter Retirement
 - Public Employees' Retirement System of Nevada
 - Include some distribution summaries of benefits in Colorado
- Most programs are specific to Firefighters
- Nevada allows volunteers of regularly organized fire department to participate in Police and Firefighter's Retirement Fund
- Wyoming also covers EMS and Search and Rescue (SAR)
- Most state-wide systems also offer deferred comp (457); however these appear to be tailored towards paid employees



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Summary of Findings

Normal Retirement Benefit

| | WY | MT | NM | NV |
|------------------------|---|---|-------|--|
| Monthly Benefit | \$16/yr. for 1 st 10 years of service, +\$19/yr. for service >10 | \$175 + \$7.50 for each year of service for years 20 to 30. Could get additional benefits for service >30 if UAL amort. <20 years | \$250 | 2.5% x Average Monthly Compensation* x Service Credit (up to 30 years) |
| 30 Yr. Service Example | \$540 | \$250 | \$250 | \$750 |
| Eligibility Age | 60 | 55 | 55 | 50/60/65 |
| Eligibility Service | 5 | 20 | 25 | 20/10/5 |

* Compensation based on "assumed salary" as a volunteer firefighter. This example assumes average monthly compensation of \$1,000.



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Summary of Findings

Termination Benefit

| | WY | MT | NM | NV |
|---------------------|------------------------|---|-------|------------------------|
| Service Requirement | 5 | 10 | 10 | 10 |
| Retirement Age | 60 | 60 | 55 | 60 |
| Monthly Benefit | Same formula as Normal | \$175, prorated for yrs. of service <20 | \$125 | Same formula as Normal |



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Summary of Findings

Credited Service

| | WY | MT | NM | NV |
|-------------------|--|--|---|---|
| Service Crediting | Based on 12 mos. of contributions; prorated if <1 yr. | 30 hours of training/yr.; must serve with same fire company for entire fiscal year | Attend 50% of scheduled drills and business meetings, and participate in 50% of calls responsible to attend | Based on "assumed service time factor" |
| Service Purchase | One-time option to purchase up to 5 years after 5 years of service | No | No | Option to purchase up to 5 years after 5 years of service |



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Summary of Findings

Death Benefits

| | WY | MT | NM | NV |
|-----------------|--|--|--------------------------------------|--|
| Pre-retirement | 66% to spouse or 33% to <21 age children (if no spouse). Lump sum equal to greater of \$5,000 or member contribution account balance to estate if no spouse/children | 100% to spouse or dependent child* | None | \$450/month; may elect from Retirement Optional forms of payment if >10 yrs. |
| Post-retirement | Same as pre-retirement** | Paid to spouse or dependent child if <40 payments made in retirement | ¾ to spouse or dependent child (<18) | Based on Retirement Option elected |

* Dependent child is under 18 or under 24 and a full-time student enrolled in accredited postsecondary educational institution.

** If no beneficiary, lump sum equal to greater of \$5,000 or member contribution account balance less benefits already paid.



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Summary of Findings

Contributions / Funding

| | WY | MT | NM | NV |
|------------|--|--|---------------|--------------------------|
| Primary | Tax on fire insurance premiums | State pays 5% of certain fire insurance premiums | Not available | None |
| Member | \$18.75/mo. for firefighter/EMT; \$37.50/mo. for search and rescue | None | Not available | None |
| Department | May pick up member contributions | None | Not available | 31%* of "assumed salary" |

* As of the date of this report. Rates are actuarially determined and adjusted as needed.



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Summary of Findings

Colorado Local Program Benefits

- Most programs provide Normal Retirement Benefits at age 50 with 20 or more years of service
- Termination benefits after 10 years of service; generally lower (prorated) amount
- Years of service credited based on volunteering 36+ hours in a year
- Funded at local level; State provides supplemental funding
- Normal Retirement Benefit amount distribution (as of September 2016 report):

| Monthly Benefit Level | # of Plans | % of Total |
|-----------------------|------------|-------------|
| <\$100 | 37 | 16% |
| \$100 - \$300 | 87 | 37% |
| \$301 - \$650 | 78 | 33% |
| \$651 - \$1,000 | 26 | 11% |
| \$1,000+ | 7 | 3% |
| Total | 235 | 100% |



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Limitations and Reliances

In preparing this report, we relied, without audit, on readily available information for each program. This information includes, but is not limited to, statutory and plan provisions. We found this information to be reasonably consistent and comparable with information used for other purposes. If any of this information is inaccurate or incomplete our findings may be different and need to be revised.

The findings in this report are for the purposes stated herein. They may not be appropriate for other purposes.

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- The Client may provide a copy of Milliman's work, in its entirety, to the Client's professional service advisors who are subject to a duty of confidentiality and who agree to not use Milliman's work for any purpose other than to benefit the Client.
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The consultants who worked on this assignment are retirement actuaries. Milliman's advice is not intended to be a substitute for qualified legal or accounting counsel.



Robert L. Schmidt, FSA, EA, MAAA
Principal and Consulting Actuary



Joel E. Stewart, FSA, EA, MAAA
Principal and Consulting Actuary



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Idaho Legislature, Office of Performance Evaluation

Volunteer EMS Retirement Benefit Study Phase 2 – Cost Analysis Report

Robert Schmidt, FSA, EA, MAAA

Joel Stewart, FSA, EA, MAAA

NOVEMBER 1, 2021



Summary of Plan Provisions

Costs for the following defined benefit (DB) plan options were determined

| | Option 1 | Option 2 |
|---|--|--|
| Normal Retirement Monthly Benefit Age/Service Eligibility | \$250 60/10 | \$250 55/25 |
| Termination Monthly Benefit Service Requirement Age Payable | \$250 10 years Age 60 | \$250, prorated for service <25 10 years Age 55 |
| Pre-retirement Death Benefit | 75% of Termination Benefit payable at member age 60 to spouse; lump sum of 2x Monthly Termination Benefit if no spouse | 75% of Termination Benefit payable at member age 55 to spouse; lump sum of 2x Monthly Termination Benefit if no spouse |
| Post-retirement Death Benefit | 75% of benefit payable to spouse only | 75% of benefit payable to spouse only |
| Disability | Same as Termination Benefit | Same as Termination Benefit |

- In addition, costs for a defined contribution (DC) option (Option 3) were developed:
 - Defined contribution of \$1,260 paid at end of each year if eligible, indexed annually. This is based on 3% of the current average EMS salary in Idaho, as provided by OPE, and includes a six-month eligibility waiting period and 100% immediate vesting.



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Summary of Findings

Discussion

- The “annual cost of benefits” shown on slides 7 and 8 for Options 1 and 2 **only** is the normal cost calculated under the Entry Age Normal actuarial cost method (level dollar). This amount, if funded each year and all assumptions are met, including annual return on assets of 6.3%, would accumulate the assets needed to pay benefits in retirement.
 - The annual cost of benefits for the DC Plan option (Option 3) is the anticipated contribution to the DC account for all assumed eligible members. Interest earnings on account balances are not included in the projected DC cost.
- Members are assumed to enter the program with zero years of service for benefit and eligibility purposes.
- Results are shown two ways: (1) assuming members earn a year of benefit and eligibility service each year, and (2) assuming members earn one year of benefit and eligibility service every two years.
 - In other words, depending on the stated service threshold for benefit eligibility, members would take about twice as long to become eligible for benefits under the plan.



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Summary of Findings

Discussion

- Costs were provided under three different assumed levels of turnover (low, medium and high), to show the sensitivity of costs to that particular assumption.
 - PERSI assumption for paid Safety Employees with all employees assumed to have zero years of service was used for the medium-level turnover assumption
 - PERSI assumption for paid Safety Employees starting at year five was used for the low-level turnover assumption
 - Since the PERSI tables are not for volunteers, we used a table from a representative large State-wide volunteer firefighter/EMS system for the high-level turnover assumption.
 - See the Assumptions Appendix for detail on each assumption.
- The defined benefit cost calculation is sensitive to the level of assumed turnover in the early years of a member’s career.



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Summary of Findings

Discussion

- The defined contribution (DC) option was priced by projecting the population out 20 years, to get an idea of the longer-term number of new entrants, and thus likely ineligible, each year.
 - Approximately 98% of the total population is eligible under the “low” and “medium” turnover assumptions, and approximately 90% under the “high” turnover scenario.
 - The slide 8 scenario assumes half the population attains the year of service threshold in any given year.
 - The DC costs shown are an expectation of the ultimate annual cost of the program in 2021-22 dollars. In the initial years the costs will be lower depending on the levels of turnover.
 - “Annual cost” for the DC Plan option (Option 3) is the anticipated contribution to the DC account for all assumed eligible members. Interest earnings on account balances are not included in the projected DC cost.
- The DC costs can be reduced pro-rata by reducing the annual contribution, if the costs seem prohibitive.
- A DC plan has no ongoing liability to the System other than the annual contribution, whereas a DB plan could have potential unfunded liability in the future if actual experience deviates from assumption and/or the annual accruals are not funded.



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Summary of Findings

Cost Analysis – Full Year of Service Earned per Fiscal Year (7/1-6/30)

| | Option 1 | Option 2 | Option 3 ¹ |
|--|-------------|-----------|-----------------------|
| Annual Cost of Benefits – Low Turnover | \$1,620,000 | \$950,000 | \$2,420,000 |
| Average Annual Cost per Member – Low Turnover | \$830 | \$480 | \$1,230 |
| Annual Cost of Benefits – Medium Turnover | \$1,390,000 | \$830,000 | \$2,410,000 |
| Average Annual Cost per Member – Medium Turnover | \$710 | \$420 | \$1,230 |
| Annual Cost of Benefits – High Turnover | \$850,000 | \$520,000 | \$2,230,000 |
| Average Annual Cost per Member – High Turnover | \$430 | \$270 | \$1,140 |

1. Costs in future years would assume to increase at 3.05% per annum, the PERSI wage growth assumption. Annual costs could be scaled down ratably by reducing the contribution.

Members are assumed to earn a year of service for each fiscal year (7/1-6/30) of employment.

See Appendix for additional detail on all assumptions, including detail on the three turnover assumptions.



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Summary of Findings

Cost Analysis – Full Year of Service Earned Every Other Fiscal Year (7/1-6/30)

| | Option 1 | Option 2 | Option 3 ¹ |
|--|-----------|-----------|-----------------------|
| Annual Cost of Benefits – Low Turnover | \$590,000 | \$260,000 | \$1,130,000 |
| Average Annual Cost per Member – Low Turnover | \$300 | \$130 | \$580 |
| Annual Cost of Benefits – Medium Turnover | \$380,000 | \$170,000 | \$1,120,000 |
| Average Annual Cost per Member – Medium Turnover | \$195 | \$90 | \$570 |
| Annual Cost of Benefits – High Turnover | \$100,000 | \$50,000 | \$1,020,000 |
| Average Annual Cost per Member – High Turnover | \$50 | \$25 | \$520 |

1. Costs in future years would assume to increase at 3.05% per annum, the PERSI wage growth assumption. Annual costs could be scaled down ratably by reducing the contribution.

Members are assumed to earn one year of service every two fiscal years (7/1-6/30) of employment (or half of the time).

See Appendix for additional detail on all assumptions, including detail on the three turnover assumptions.



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Summary of Findings

Summary

- Assuming lower levels of turnover increases the Defined Benefit costs by about 15% from the medium assumption under the full year of service scenario (slide 7).
 - This is important since the hypothetical program is being implemented mid-career for some members, and so their behavior may differ from a true “new hire”.
- The higher turnover assumption from a large, representative State-wide Volunteer system reduces the Defined Benefit costs approximately 40% from the medium assumption under the full year of service scenario (slide 7).
- Assuming members earn one year of service one-half of the time dramatically reduces the costs of the program (slide 8).
 - This is due to the length of time it takes to become eligible and the impact of discounting.
 - For example, under Option 1, it would now take 20 years to become eligible for benefits. Benefit payments are assumed to begin later and last for a shorter duration since life expectancy will remain the same.



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Summary of Findings

Summary

- We have not explored any legal issues with respect to the proposed plan changes. We are not attorneys and cannot give legal advice on such issues. We suggest that you review this proposal with counsel.
- In particular we have not explored legal and/or tax implications of providing a Defined Contribution to unpaid volunteers, including the taxable income impacts to the individual member. You should explore this issue with qualified legal and/or tax advisors.



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Certification

Milliman has developed certain models to estimate the values included in this presentation. The intent of the models was to estimate pension liabilities and costs. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice.

In preparing this material, we relied, without audit, on information (some oral and some in writing) supplied by Idaho Legislature, Office of Performance Evaluation ("OPE") Staff. This information includes, but is not limited to, plan provisions and member census data. We found this information to be reasonably consistent and comparable with data used for other purposes. The valuation results depend on the integrity of this information. If any of this information is inaccurate or incomplete our results may be different, and our calculations may need to be revised.

All costs, liabilities, rates of interest, and other factors for the System have been determined on the basis of actuarial assumptions and methods which are individually reasonable (taking into account the experience of the System and reasonable expectations); and which, in combination, offer our best estimate of anticipated experience affecting the System. Further, in our opinion, each actuarial assumption used is reasonably related to the experience of the Plan and to reasonable expectations which, in combination, represent our best estimate of anticipated experience under the System.

This analysis is only an estimate of the System's financial condition as of a single date. It can neither predict the System's future condition nor guarantee future financial soundness. Actuarial valuations do not affect the ultimate cost of System benefits, only the timing of System contributions. While the valuation is based on an array of individually reasonable assumptions, other assumption sets may also be reasonable and valuation results based on those assumptions would be different. No one set of assumptions is uniquely correct. Determining results using alternative assumptions is outside the scope of our engagement.

Future actuarial measurements may differ significantly from the current measurements presented in these exhibits due to many factors, including: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements and changes in plan provisions or applicable law. Due to the limited scope of our assignment, we did not perform an analysis of the potential range of future measurements. The OPE has the final decision regarding the appropriateness of the assumptions and actuarial cost methods.

Actuarial computations presented in this presentation are for purposes of determining the recommended funding amounts. Determinations for purposes other than meeting this requirement may be significantly different from the results contained in this presentation. Accordingly, additional determinations may be needed for other purposes.



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Certification

These cost estimates are subject to the uncertainties of a regular actuarial valuation; the costs are inexact because they are based on assumptions that are themselves necessarily inexact, even though we consider them reasonable. Thus, the emerging costs may vary from those presented in this letter to the extent actual experience differs from that projected by the actuarial assumptions.

We have not explored any legal issues with respect to the proposed plan changes. We are not attorneys and cannot give legal advice on such issues. We suggest that you review this proposal with counsel.


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The consultants who worked on this assignment are retirement actuaries. Milliman's advice is not intended to be a substitute for qualified legal or accounting counsel.

On the basis of the foregoing, we hereby certify that, to the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices which are consistent with the principles prescribed by the Actuarial Standards Board and the Code of Professional Conduct and Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States of the American Academy of Actuaries. We are members of the American Academy of Actuaries and meet the Qualification Standards to render the actuarial opinion contained herein.



Robert L. Schmidt, FSA, EA, MAAA
Principal and Consulting Actuary



Joel E. Stewart, FSA, EA, MAAA
Principal and Consulting Actuary



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Summary of Assumptions

- Based on July 1, 2021 valuation date
- Primarily based on PERSI July 1, 2021 Public Safety Valuation
- Costs calculated using the individual Entry Age Normal actuarial cost method, level dollar
- Investment earnings: 6.30%, net of all expenses
- Wage inflation: 3.05%
- Mortality (base tables):
 - Pre-retirement – Pub-2010 Safety Employee
 - Healthy Retiree – Pub-2010 Safety Retiree, increased 21% for males and 26% for females
 - Beneficiary – Pub-2010 General Retiree, increased 11% for males and 21% for females
 - Disabled Retiree – Pub-2010 Disabled Retiree, increased 38% for males and 26% for females
- Future mortality improvement: projected generationally from 2010 using the 60-year geometric average of the mortality improvement rates reported by the Social Security Administration from 1957 through 2017, blended 50% male and 50% female



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Summary of Assumptions

- Retirement (if eligible):

| Age | First Year | After | Age | First Year | After | Age | First Year | After |
|-----|------------|-------|-----|------------|-------|-----|------------|-------|
| 55 | 29% | 24% | 60 | 14% | 25% | 65 | 34% | 37% |
| 56 | 25% | 16% | 61 | 16% | 16% | 66 | 34% | 33% |
| 57 | 27% | 20% | 62 | 16% | 26% | 67 | 34% | 27% |
| 58 | 24% | 18% | 63 | 16% | 21% | 68 | 34% | 35% |
| 59 | 24% | 20% | 64 | 16% | 17% | 69 | 34% | 31% |

- Retirement rates under the "First Year" column apply the first year a member is eligible for retirement, and the retirement rates under the "After" column apply for all years thereafter.
- Full retirement is assumed at age 70, or age first eligible if later.
- 80% of participants are assumed to be married, with males two years older than females
- Members are assumed to enter the program with zero years of service for benefit and eligibility purposes



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Summary of Assumptions

- Disablement:

| Age | Rate | Age | Rate |
|-----|--------|-----|--------|
| 20 | 0.012% | 45 | 0.123% |
| 25 | 0.012% | 50 | 0.285% |
| 30 | 0.021% | 55 | 0.400% |
| 35 | 0.047% | 60 | 0.000% |
| 40 | 0.075% | | |

- Turnover – Medium Assumption (from PERSI Paid Safety Employees)

| Service | Rate | Service | Rate | Service | Rate | Service | Rate | Service | Rate |
|---------|-------|---------|------|---------|------|---------|------|---------|------|
| 0 | 17.1% | 5 | 6.8% | 10 | 3.9% | 15 | 2.7% | 20 | 1.5% |
| 1 | 12.8% | 6 | 6.2% | 11 | 3.7% | 16 | 2.4% | 21 | 1.4% |
| 2 | 9.4% | 7 | 5.5% | 12 | 3.5% | 17 | 2.1% | 22 | 1.4% |
| 3 | 8.7% | 8 | 4.8% | 13 | 3.2% | 18 | 1.8% | 23 | 1.3% |
| 4 | 7.5% | 9 | 4.2% | 14 | 3.0% | 19 | 1.5% | 24+ | 1.3% |



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Summary of Assumptions

- Turnover – Low Assumption (PERSI Paid Safety Employees starting year 5)

| Service | Rate | Service | Rate | Service | Rate | Service | Rate | Service | Rate |
|---------|------|---------|------|---------|------|---------|------|---------|------|
| 0 | 6.8% | 5 | 3.9% | 10 | 2.7% | 15 | 1.5% | 20 | 1.3% |
| 1 | 6.2% | 6 | 3.7% | 11 | 2.4% | 16 | 1.4% | 21 | 1.3% |
| 2 | 5.5% | 7 | 3.5% | 12 | 2.1% | 17 | 1.4% | 22 | 1.3% |
| 3 | 4.8% | 8 | 3.2% | 13 | 1.8% | 18 | 1.3% | 23 | 1.3% |
| 4 | 4.2% | 9 | 3.0% | 14 | 1.5% | 19 | 1.3% | 24+ | 1.3% |

- Turnover – High Assumption (representative large State-wide volunteer firefighter/EMS system)

| Service | Rate | Service | Rate | Service | Rate | Service | Rate |
|---------|------|---------|------|---------|------|---------|------|
| 0 | 17% | 5 | 15% | 10 | 10% | 23 | 6% |
| 1 | 18% | 6 | 14% | 11-14 | 9% | 24 | 8% |
| 2 | 19% | 7 | 13% | 15 | 7% | 25 | 8% |
| 3 | 19% | 8 | 12% | 16-18 | 6% | 26 | 8% |
| 4 | 18% | 9 | 11% | 19-22 | 5% | 27+ | 8% |



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Summary of Data

- Count: 1,962
- Average Age: 42.4 years
- Percent Female: 42%
- Missing Age: assumed equal to the average age of 42
- Participant distribution*:

| <25 | 25-30 | 30-35 | 35-40 | 40-45 | 45-50 | 50-55 | 55-60 | 60-65 | 65+ |
|-----|-------|-------|-------|-------|-------|-------|-------|-------|-----|
| 221 | 177 | 212 | 208 | 225 | 178 | 170 | 165 | 128 | 164 |

* Excludes 114 records for whom no age was provided



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Risk Disclosure

- The results of any actuarial valuation are based on one set of assumptions. Although we believe the current assumptions for the System provide a reasonable estimate of future expectations, it is almost certain that future experience will differ from the assumptions to some extent.
- To the extent actual experience for these factors varies from the assumptions, this will likely cause either increases or decreases in the future funding level and calculated costs.
- Examples of factors that can have a significant impact on valuation results are:
 - Investment return different than assumed; impacts the value of accumulated assets available to pay benefits
 - Mortality experience; impacts how long retirees receive benefits
 - Retirement age experience; impacts timing and duration of retirement payments
 - Turnover experience; impacts size of payments
- Slides 7 and 8 provide sensitivity of the costs to the turnover assumption, for example.



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Responses to the evaluation



The report highlights the delicate balance the state faces to maximize community resources while preserving quality care and patient safety, particularly in rural Idaho....I am committed to working with stakeholders across the state to improve these critical services.

—Brad Little, Governor



The department looks forward to continuing the conversation about this critical topic with policy makers following the release of the report.

**—David Jeppesen, Director
Department of Health and Welfare**



BRAD LITTLE
GOVERNOR

November 15, 2021

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Via Email: rmohan@ope.idaho.gov

Dear Director Mohan:

Thank you for your office's report on the state's volunteer providers of emergency medical services program. The report highlights the delicate balance the state faces to maximize community resources while preserving quality care and patient safety, particularly in rural Idaho.

I appreciate your office's thoughtful consideration of this balance in preparing the report. One of Idaho's greatest assets is its sense of community and the willingness of our residents to serve one another. Volunteers in our communities play a critical role in making Idaho the place where economies are strong, families thrive, and our children and grandchildren choose to stay. I appreciate the time and attention on how we can develop the best system and delivery of volunteer emergency medical services throughout the state. I look forward to seeing how this report will impact emergency medical services and guide the Department of Health and Welfare and policy makers to make informed decisions related to emergency medical services.

Again, thank you for work on this important issue, and I am committed to working with stakeholders across the state to improve these critical services.

Sincerely,

A handwritten signature in blue ink, appearing to read "Brad Little", is written over a light blue circular background.

Brad Little
Governor



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

OFFICE OF THE DIRECTOR
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

November 15, 2021

Office of Performance Evaluations
Attn: Rakesh Mohan
954 W. Jefferson St. Suite 202
Boise, Idaho 83702

Dear Director Mohan,

Please accept this letter as our formal response to the final report on “*Volunteer Providers of Emergency Medical Services*” dated November 5, 2021. We appreciate the opportunity to collaborate with your team to explore sustainable solutions that will result in increased recruitment and retention of the volunteer emergency medical services (EMS) personnel on whom our rural communities rely for emergency medical response.

The work done by the Department of Health & Welfare, Division of Public Health, Bureau of EMS & Preparedness is a balance between technical assistance focused on EMS system development and stability and reasonable regulatory interventions. The bureau is very deliberate in their application of regulatory solutions in situations where public safety is at risk. The first recommendation in the report (“*We recommend that the bureau improve monitoring and technical assistance for agencies to meet the response requirement.*”) demonstrates this balance as it has elements of both regulatory and technical assistance strategies.

There are three elements in the report we would like to highlight:

First, “*Provide agencies with technical assistance to improve performance data*”. This is focused on patient care report (PCR) data. We agree on the importance of PCR data and the bureau has worked for over ten years to transition Idaho from a paper form (bubble sheet) PCR to the new electronic reporting system. While the bureau is currently collecting data in a standardized way that will allow export of Idaho data to the National EMS Information System (NEMSIS), the bureau has been very deliberate and balanced in their decision-making concerning exporting state data to NEMSIS due to cost and data security concerns. Specifically, NEMSIS suffered a data breach in 2017 that caused bureau leadership to pause any data submissions until they are confident that security measures put in place following the 2017 incident are reliable. The NEMSIS data dictionary has also undergone numerous version iterations over the past several years and with each new version comes a sometimes significant cost (financial, training, staff time, etc.) to EMS agencies. Recognizing the importance of EMS patient care response data, the bureau is currently planning to resume data exports within the

next several months. Considering that the information found in a PCR is focused on the specifics of an EMS response, the bureau believes that the personnel licensure data that the bureau maintains is a better source of information on trends in volunteer EMS personnel (attrition, new licensees, age trends, etc.)

Second, *“Track agencies’ need to waive the response requirement”*. This focuses on the following language in Idaho Code §56-1016 (2) *Dispatch – Each licensed EMS agency shall have a twenty-four (24) hour dispatch arrangement and shall respond to calls on a twenty-four (24) hour basis*. As correctly point out in the report, the bureau finds enforcement of the 24-hour response requirement challenging as it is unclear at what point an agency is out of compliance. There are several reasons why an EMS agency may be unable to respond to an emergency medical call such as multiple concurrent calls or an interfacility transfer that takes the only staffed ambulance out of the response area. While both of these scenarios could be considered a violation of the referenced section of code, it is clearly not the intent nor would applying enforcement pressure be reasonable. It is unclear how applying a regulatory solution to this issue would help with the recruitment and retention of the volunteer EMS personnel who serve local communities throughout Idaho.

Third, *“The Legislature could support agency recruitment and retention efforts by providing financial compensation, benefits and training.”* We agree with this recommendation. The specific strategies contained in this section of the report closely mirror the findings from our 2012 and 2018 Volunteer EMS Town Hall Meetings. In order to better understand the potential benefits, the bureau is currently surveying state EMS offices on their volunteer EMS recruitment and retention strategies and outcomes. We hope the results of the survey will help inform decision makers as they contemplate the recommendations in the report. Results are expected by the end of November 2021.

In closing, I would like to express the gratitude of the Department of Health and Welfare for the work of your team in providing a review of an otherwise complex public health challenge. The department looks forward to continuing the conversation about this critical topic with policy makers following the release of the report.

Sincerely,



DAVE JEPPESEN
Director

DJ:wd

